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CLINICAL LECTURES.

CATARRHAL COLITIS—"WALKING" PNEUMONIA—GASTRO-INTESTINAL SYMPTOMS—AORTIC ANEURISM.

BY FRANCIS DELAFIELD, M. D.,

PROFESSOR OF PATHOLOGY AND PRACTICE OF MEDICINE, COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK.

Catarrhal Colitis.

Gentlemen: This man says he is fifty-three years old, and a painter by trade. For twenty years he has had some stomach symptoms, including distress after eating, and occasional vomiting of food; and he has always been constipated. But the illness for which he comes here to-day, is one which he has had only five weeks. During this time he has had ten or twelve small passages daily, and has also passed blood and mucus. His temperature to-day is 98.4° F.; his urine

has a specific gravity of 1.013; it contains no albumin.

It is hardly necessary, I think, for us to take into account his old history of gastric catarrh, for that has no immediate bearing upon his present condition; what has brought him here is the illness which has lasted five weeks. The many passages which he has during the day are not preceded by pain. As you see, there is nothing out of the way about the urine, except that the specific gravity is a little low. The man is not confined to bed; he is able to be up and about.

The first question would be: Where is the lesion which has caused these numerous passages? You reply that it is in the colon. To be more definite, it is in the lower part of the colon. We can judge that from the frequent and continued passage of blood and mucus and from the fact that the passages are small. This usually means that the upper part of the colon is not involved, and that the lesion is confined to the lower part.

Then the question arises, What sort of

lesion is it? It is an inflammation. What kind of inflammation? You will remember that in the colon one of three forms of inflammation may be present, namely: catarrhal, croupous, or follicular. In this case we have the history of catarrhal colitis, which has been going on for five weeks, and was apparently at first subacute, but now has the characteristics of a chronic inflammation. We do not know exactly the history of the first week. The trouble may have commenced acutely; but the impression which we get from the man's story is that it followed first a subacute and then a chronic course.

Now the question arises: How is the man to be cured of his trouble? It has already lasted five weeks; and the longer it lasts the harder it will be to cure it. It is a matter of a good deal of importance for this man, not only to get better, but to get better as soon as possible; for in all these chronic catarrhal inflammations the longer they last the worse they are. This man, in the first place, ought to go to bed and stay there. He ought not to be up and about. In the second place, he ought, I imagine, to be exclusively on a milk diet. It is impossible to say positively whether he ought to be exclusively on a milk diet, or exclusively on a meat diet, or on a diet partly of meat and partly on milk, until a trial has been made; but one or other of these exclusive diets, he ought to be placed upon.

As to medicinal treatment: taking him as he is now I should give him no medicine by the mouth, but I should give him, at first, twice a day a large enema of water as hot as it could be borne without being likely to scald, and containing boric acid, one drachm to the pint. A quart of the solution should be used at each injection. That is all that I would do at first, until I saw whether a real improvement could be brought about in that way.

"Walking" Pneumonia.

The following is the history which we have obtained from this young man: He is thirty-two years old, is a peddler by occupation, and has been more or less intemperate. Six days ago, while out at his work, he felt pain and oppression across the lower part of the chest, and felt so sick that he went home to bed. While at home he had a chilly feeling. There has been a repetition of the chills with some sweating. He is not conscious of having had fever; that is, he has not felt

particularly hot. Besides this he has had a cough, with some mucous expectoration. Four days ago he had several movements of the bowels during twenty-four hours. Last night he vomited. Yesterday his temperature was 101° F.; to-day it is 101.8°. His urine has a specific gravity of 1.011; it contains no albumin.

When we look at the man we notice a certain amount of tremulousness which might very well, however, belong to his old alcoholic history. He does not look very sick, yet he looks like a man who is suffering from some real illness. His tongue is moist, and is very slightly coated.

When we examine the chest we find on the right side, in front, from the clavicle down to the fourth or fifth ribs, very marked dulness on percussion; the breathing is not as loud over this region as it is over the corresponding region on the left side. The abdomen bears no marks of eruption.

Taking this history in connection with the man's present condition, we may ask, What is the disease from which he is suffering? Of course we are embarrassed by want of knowledge of the man's previous history, particularly the physical signs, and we might make an erroneous diagnosis at this moment. But we must take the case as it stands, suppose the history given is true and fairly complete, that he was well until last Friday, that he was then taken sick in the manner described, and that no unknown conditions existed; from what, then, is the man suffering? You say pneumonia. Yes, I think lobar pneumonia of the right upper lobe is the correct diagnosis. It is one of those cases of pneumonia which are not very common, in which we find the patient walking about. Of course most people with lobar pneumonia on the fifth day would be sick abed, and would be looking a great deal worse than this man does; but from time to time we meet with cases like this one. The patients walk into the hospital or dispensary, although at home they had been abed. They feel sick, yet they have enough strength to get up and go out. These cases, although they look very well the time you see them, yet require quite as much care as those cases which look sicker at first. They do not always continue to behave quite as well as they begin. There is never any question as to the right thing for them to do, in one regard: viz., to go to bed and remain there until the consolidation of the lung disappears. For a patient situated as

this man is, the only place for him is a hospital. To stay, as he has been staying, in his own room, without proper comforts, would be very much against him. But taking the man as he stands, he is a better example of lobar pneumonia, behaving in this exceptional way, than I am often able to show you. Yet it occasionally does behave in this way, and is then easily overlooked. If this man's chest were not examined the diagnosis could not be made. You would think very likely that he was suffering either from typhoid fever or one of the irregular fevers which are so common here. But the moment that we get such pronounced physical signs as we have here, it at once helps us in the diagnosis. It does not follow because these patients are able to get up, that the pneumonia is lighter than in others. The patients may be tougher, and bear the disease with less evidence of prostration.

Gastro-Intestinal Symptoms.

This woman is an Italian from whom we are able to get only an imperfect history. She is forty-eight years old, and for eight years has had some gastric symptoms with constipation. Her own description of the symptoms is fairly characteristic; it is that of a good deal of flatulence with more or less colic. During the past three months she has been worse, having had severe pain in the abdomen, constipation, and vomiting. The constipation has been very marked. She has lost flesh. She has never vomited blood. She complains chiefly of pain, which she refers usually to the left hypochondriac region. The urine is normal.

On looking at the abdomen it appears a little fallen in, but there is nothing unusual in the contour. There is more tenderness on the left side than on the right on superficial pressure, but firm deep pressure causes her less pain. No tumor can be felt any place. The doctor who brought her here says he has made an examination per rectum, passing the finger high up, and found nothing. I do not think I am able to make a positive diagnosis. The appearance of the woman is that of a person who has some real sickness, and from her symptoms what one would naturally look for would be a tumor; a tumor connected with the stomach or with the intestines. Such a tumor, however, can not be felt, although the abdominal wall is thoroughly relaxed, so that if a tumor of any size were present one ought to be able to feel it.

It is always perfectly possible, indeed it is not even unusual, for a person to pass into as bad a condition as this woman is in without any other cause than a chronic catarrhal gastritis, constipation, and flatulence, and an irritable condition of the colon. Yet when we first see such a case there is always an element of doubt. It is always possible that after all a tumor is present, but so small that we cannot feel it, especially if it is one of the flat infiltrations of the walls of the stomach which hardly give a tumor at all, yet which behave like cancer. The best test in these cases usually is to try the effect of treatment, and observe whether they do, or do not, improve. If it is only a catarrhal gastritis and a disturbance of the colon they get better. If it is a new growth, of course they go on getting steadily worse.

I should suppose the proper way to manage this case would be to put the woman on an exclusive milk diet, to wash out the stomach every day with warm water, and see that she has a movement of the bowels every day either by means of an enema or by means of medicine, and in a woman of her age probably the best medicine for moving the bowels would be a combination of aloes and strychnia.

Aneurism of the Arch of the Aorta.

Our next patient is a large man, thirty-seven years old, and a carpenter by occupation. Last winter he had an attack of pneumonia, and has not been able to work since. He has had bronchitis, pain across the chest, hoarseness, cough, and shortness of breath. He gained some in flesh during the past summer, but is still unable to work. He has difficulty in speaking, and examination with the laryngoscope shows paralysis of the left vocal cord.

Physical examination further reveals dullness over the upper part of the chest, beginning well over on the left side and extending over to the right side of the sternum. Over the same portion of the chest there is a distinct pulsation, and those who are near can see my hand rise and fall with the pulsations through the walls of the chest. Yet the heart's action is not particularly forcible; it does not correspond in force with the pulsation in this region. There is some difference between the contour of the chest in this region and in the corresponding region on the other side, it being fuller on this. There is no murmur, but the heart is some-

what increased in size. The left radial pulse is weaker than the right.

This case reminds us of one present last Thursday—a man in whom we also found dulness on percussion over the upper portion of the chest on the left side, who in the same way had lost his voice, the laryngoscope showing paralysis of one vocal cord. The man had some dyspnoea on exertion. But there was no change in the contour of the chest at all. There was no bulging, and no pulsation. There was nothing but marked dulness on percussion, and evidence of pressure backward on one recurrent laryngeal nerve, shown by the paralysis of the vocal cord. You may remember that in that man the diagnosis, although not positive, was probably a tumor; not an aneurism, but a new growth within the cavity of the thorax. In the present case, with dulness in the chest at the same location, with paralysis of one of the vocal cords, and hoarseness, you observe that other symptoms are present to make the diagnosis of aneurism perfectly straightforward. There is not only dulness here, but there is some bulging of the chest, a distinct heaving impulse, yet no murmur; there is hypertrophy of the left ventricle of the heart, the radial pulse is weaker on the left side than on the right side. Still further, this man is much less able to work than the other. Although he has kept his flesh fairly well, and although he is well enough nourished, yet he is incapacitated from work by the presence of an aneurism of the transverse and descending portion of the arch of the aorta, for that is the seat of the trouble in his case. In showing you this case you can better appreciate why I was in doubt about the diagnosis in the case presented last week. It was more probable, in that case, that the tumor was a new growth, but the diagnosis was not positive. In this case there is no doubt about the diagnosis.

NUMBER OF DENTISTS IN GERMANY.—According to Dr. Paul Börner's "Reichs-Medicinal Kalender für Deutschland" for the year 1888 there are 16,864 medical men and 514 dentists in practice among a population of 46,840,587 inhabitants in the German Empire, while the number of chemists' shops is 4,671, and of hospitals 2,737. In face of these figures, it may be truly said that the dental profession is not overcrowded in the Fatherland.

DIABETES MELLITUS.¹

BY JAMES TYSON, M. D.,

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Gentlemen: The patient whom I show you this morning presents a brief, but interesting history. The family history, which is not altogether unimportant in this disease, is, in her case, negative. As to her own history, she has had small-pox, typhoid and relapsing fever. Her work has been that of a domestic. She is sixty-eight years old, and has been a hard worker through life, as indeed her appearance shows. There is no history of syphilis; but she has always suffered from constipation.

Her present disease began about one year ago, and announced itself by dryness of the skin and mouth, thirst, increased urination and cramps. These last occurred especially at night. Her most distinctive symptoms were gradual emaciation, increased urination, thirst and cramps in the legs. This combination at once suggests an examination of the urine for sugar. There are several tests for sugar; but I shall use that of Fehling, because it is the best, the quickest and the most satisfactory. It can be used roughly as a quantitative test even in the consulting room, because one-half a cubic centimetre of the solution is just decolorized by five milligrams of sugar, or, to present the subject in another form, a quantity of urine that will be decolorized by an equal volume of Fehling's solution contains one-half of one per cent. of sugar. To use Fehling's solution it is best to dilute it first with four parts of water; because, if it has spoiled, as it easily does, this dilution will indicate it more quickly; while the color of the undiluted Fehling's solution is too dense for us to recognize easily the exact moment of the complete reduction of the copper. Before attempting the test with the urine, the quantity of Fehling's solution used should be boiled, for the boiling will of itself precipitate the suboxide of copper if the solution has spoiled. By boiling this sample of Fehling's before you, I show that it is intact. Now by boiling together the urine and Fehling's solution in equal quantities, I at once get a reduction of the protoxide to the suboxide of copper, and from its precipitation

¹ Delivered at the Philadelphia Hospital.

a change in the color of the mixture. Moreover, as the solution is more than reduced, it is plain there is present more than one-half of one per cent. of sugar in the sample of urine. If the sugar occurs in such a large quantity as is evidently here present, it is better to dilute the urine if we desire to make a quantitative analysis.

The second question to decide is the amount of the urine and sugar passed in a day. When the patient first came into the hospital, ten days ago, she passed three hundred and twenty ounces of urine during the day. This amount gradually increased until on her seventh day in the hospital she voided during the twenty-four hours four hundred and forty ounces, which contained two and a half per cent. of sugar, or eight ounces in all. Up to this time she has been on the common, mixed diet of the hospital, because we want to know precisely where we stand before beginning any plan of treatment. The ordinary quantity of urine passed a day in health is from forty to fifty ounces. These facts alone enable us to say with certainty that the patient has diabetes mellitus.

It may be said of this disease that there is perhaps none of which there is so little preciseness of knowledge when contrasted with the amount of information which has been in various ways brought to bear upon it. It may be said, however, that there are three difficult conditions characterized by glycosuria. The first is a simple glycosuria, caused by the ingestion of too large amount of sugar and starch, which disappears on the restriction or withdrawal from the patients' food of these substances. There can be no doubt, however, that such conditions, if neglected, may go on to true diabetes. These patients do not pass large quantities of water; they have no thirst, nor dryness of the mucous membranes, and their glycosuria is generally overlooked until the patient attempts to get his life insured or has his urine analyzed for some other reason.

The second form of glycosuria is the result of lesion in certain portions of the brain, either by degenerative changes, traumatism, or by tumors most frequently, either directly or indirectly connected with the floor of the fourth ventricle. This condition may be called a symptomatic diabetes, and, if the nervous condition upon which it depends can be cured, the glycosuria will disappear. The patients perish, as a rule,

not from the glycosuria, but from the lesion of which it is merely a symptom.

The third variety is the essential or real diabetes, and of its exact pathology there is least known. Its striking symptoms are the passing of large quantities of saccharine urine, great thirst and progressive emaciation. Here too the nervous system becomes the medium of the glycosuria by influencing the circulation in the liver. This organ, it is well known, is the seat where the starch is converted into glycogen, and thence into glucose or grape sugar. In diabetes mellitus, from some illy understood nervous condition, this latter change takes place too rapidly, and the glucose passes out in the urine. At the same time, in case after case of essential diabetes, the autopsy has afforded no satisfactory explanation of the condition. Let me, however, emphasize this fact, that diabetes mellitus is not a disease of the kidneys, as so many suppose. It is a general affection that simply manifests itself through these organs.

The fact that sugar and starch are not appropriated by the system, but merely pass directly through it, in the shape of glucose, furnishes us with the key of treatment, viz.: to omit these two substances from the patient's food. This alone, in many cases, will stop the disease in its early stages, and while this is the case there is no need of medication by drugs.

My method of managing a case of diabetes mellitus is as follows: While the patient is living on a mixed food a quantitative analysis of his urine for sugar is made. Then remove from his diet all starchy or saccharine articles. The quantities of sugar and of urine will immediately decrease. In many cases, if instituted sufficiently early, no other treatment will be needed. Nor is it always necessary to remove all articles that contain traces of these offensive materials. Indeed, it often happens that a too exclusively nitrogenous diet will not agree with the patient, even if he could be made to tolerate it.

To speak more specifically upon this subject of a patient's diet, you should eliminate:

1. Bread, which is the worst thing he can eat. Gluten flours are, in the main, frauds. They contain from sixty to seventy per cent. of starch, while common wheaten flour contains only seventy-five per cent. There are one or two exceptions to this rule, in which the samples of gluten flour contain only from five to ten per cent. of starch; but the

bread made from these is so uninviting, in its appearance and its taste, that most patients prefer to have no bread at all. 2. Sugar is to be absolutely prohibited in all cases. 3. Then potatoes, both Irish and sweet, rice, peas, and the whole category of starchy foods are prohibited.

The articles to be allowed are meat and fish, both fresh and salt. Oysters, though they used to be prohibited, because they contain a small amount of sugar, may be allowed. This objection was theoretical rather than practical, as they do not contain enough sugar to be harmful. Of vegetables allow spinach, celery tops, tomatoes, cabbage and cauliflower. If wines are necessary, recommend those that do not contain sugar, such as claret and very dry sherry, and for this reason whiskey is to be preferred to wine or brandy.

It is a singular fact that certain kinds of sugar are assimilable, at least in mild cases. Such are sugar of milk and that of some fruits; hence milk is not usually interdicted in such cases. Indeed Donkin suggested a treatment by skim-milk, which is efficient in certain cases, not in curing, but in keeping the sugar out while used.

Undoubtedly skim-milk is better than unskimmed. The only explanation of this I can suggest is that in skimmed milk the fat, which is especially difficult for the liver to digest, is removed.

Of fruits, the orange may often be taken with impunity. So may the apple, while the pear and peach are not so harmless. Grapes are especially prejudicial on account of the grape sugar which they contain.

No drugs will remove sugar on an improper diet. I prefer always to do the best I can without them, and finally resort to them as helpers when diet of itself is insufficient. Opium has power to diminish or remove sugar by means of any of its alkaloids. The best has been thought to be codeia, but I find morphia equally efficient. The alkaloids are preferred to the gum opium, because they are more certain in their effects and less bulky in dose. Morphia is one-eighth as costly as codeia. If morphia is used you should begin with one-quarter of a grain a day and increase. I have used as much as forty grains of codeia daily, and fifteen to twenty of morphia, by gradually increasing the dose.

But these remedies are not without disadvantage. In the course of time the mind of the patient, both from the diabetes and

the opium, will gradually become sluggish and inactive, and the character less manly and firm, so that it is exceedingly desirable to find a drug that will possess the virtues of opium without its disadvantages.

Lately much has been said about anti-pyrin, especially by the French physicians, who claim wonderful results. My own experience, though limited, has not sustained this view. It is given both alone and in combination with the bi-carbonate of sodium, of each fifteen grains three or four times a day. With these drugs I treated three cases, all women, with the following results. In the first the sugar fell off slightly, but to less degree than on a more stringent diet. In the second there was no effect. In the third case there was no effect on the sugar, while the patient was nervous and generally miserable until the use of the drug was stopped.

Of the other drugs the reports are uncertain. Ergot does well in some cases, particularly in cases of diabetes insipidus, or in cases that are just on the border line between diabetes insipidus and diabetes mellitus. Patients who pass much urine and little sugar are benefited by ergot. Alkalies are beneficial, especially in the form of alkaline mineral waters, with careful diet. The value of mineral waters or of alkalies without this precaution has never been fully determined. Indeed, the rest and dieting at Karlsbad and other health resorts do as much in most instances to effect the cure as the water; for the use of all drugs without dieting is a loss of time. Of tonics arsenic in some cases is helpful. Martineau in France, following the suggestion of Rouget, has used carbonate of lithium and arseniate of sodium, and claims by this treatment to cure ninety-five per cent. of his patients. A surprising statement, confirmed by no one.

The simplest way to use these drugs is in a pill containing one-twenty-fifth of a grain of the arseniate of sodium, with one-and-a-half grains of the lithium carbonate, to be given twice a day after meals.

IN FRANCE the doctor's claim on the estate of a deceased patient has precedence of all others. Even the landlord's claims for arrears of rent must yield to the doctor's fee. The courts have decided that as it is an imperative right of humanity that the dying should have the necessary care and treatment, such attendance should be paid for before all other debts.

COMMUNICATIONS.

CASE OF ACONITE POISONING.

BY BYRON F. DAWSON, M. D.,
KEWANNA, INDIANA.

The report of a case of aconite poisoning, by Dr. Clara T. Dercum, in the *REPORTER* of October 5, 1889, prompts me to send you the following report.

On May 22, 1888, at about 3 P. M., a woman rushed into my office, slammed the door after her, and hastily took a seat, and in a frantic way said, "Oh, for God's sake do something for my baby!" which latter she carried in her arms. Her actions made me first think of an insane person, but the mystery was soon solved. She lived three miles in the country, and while cleaning house a number of bottles of medicine were removed from an old cupboard and placed in a window, where the child, a female, aged about sixteen months, found one, and having removed the cork, placed the bottle to the lips and swallowed an unknown quantity of its contents. The nearly emptied uncorked vial on the floor, and the child, were soon found. The latter began to show symptoms of serious illness, and the mother administered such domestic remedies as she thought the case demanded, as milk, fat meat, etc., not knowing the nature of the medicine taken. Her husband hitched the horse and buggy, and she brought the child to town alone. It was nearly an hour after the poison was swallowed before I saw the case. The child was greatly prostrated, and was vomiting every two or three minutes, the skin was pale, relaxed, cold, and covered with a profuse perspiration; the radial pulse was imperceptible, the heart's action very weak, respiration very feeble and irregular, the eyes partially closed, and the pupils dilated.

I at once administered some brandy and fluid extract of digitalis, which were repeated as often as was considered safe, but the child was vomiting everything taken into the stomach.

It was at this point that the mother produced a one-ounce vial which she said she thought was the cause of the mischief. It contained a few drops of fluid of a reddish color, which I tasted and immediately recognized as tincture of aconite; and at once informed the mother the child had swallowed

a rank poison. The medicine had been prescribed during the preceding winter by a neighboring horse-doctor for a horse sick with pneumonia, and, when the vial was shown to him later he recognized the contents by the directions written on the label, and stated it was tincture of aconite.

I had the child wrapped warmly, kept it in a recumbent position, excluded all draughts of air, and persisted in the use of the brandy and digitalis, notwithstanding the child continued to vomit oftener than every five minutes, for the next two hours; but by that time a pulse at the wrist could be felt. In another hour the heart's action and pulse had become stronger, the respirations were deeper and more regular, the perspiration had about ceased, and the fits of vomiting were less frequent. I remained with the case until 9.30 P. M., when the skin was warm, the vomiting had then ceased more than an hour before, the child had nursed her bottle, and was sleeping naturally. I dismissed the case at that time and it required no further attention. The child was in her usual health in a day or two.

THE ANATOMICAL RELATIONS OF LESIONS OF THE HEART AND THE KIDNEYS IN BRIGHT'S DISEASE.¹

FROM THE STUDY OF THREE HUNDRED
AUTOPSIES.

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(Concluded from page 694.)

Considering the two forms of Bright's disease apart, we find that general hypertrophy co-exists more frequently with parenchymatous nephritis, viz., in 29 per cent.; while hypertrophy of the left ventricle alone was met with in 26 per cent. in this form of Bright's disease. Hypertrophy of the left ventricle predominates in interstitial nephritis, showing 44 per cent. to 26 per cent. of the parenchymatous. General hypertrophy occurred in interstitial nephritis in 28 per cent.

¹ Read before the Association of American Physicians, 1889.

I obtained also figures which vary somewhat in the two series of cases tabulated.

Series A. Coroner's and private cases.

—Hypertrophy of heart in connection with the parenchymatous forms of nephritis, occurred in 54 per cent. of the cases,¹ and in the interstitial nephritis in 92 per cent.

Series B. Hospital cases.—Hypertrophy of heart in connection with parenchymatous nephritis occurred in 56 per cent. of all cases, and in interstitial nephritis in 60 per cent.²

RELATION TO VALVULAR DISEASE.

The relation of valvular disease to the two forms of Bright's disease (the parenchymatous and the interstitial) appears to be an indefinite one.

Valvular disease without hypertrophy proves to be nearly equally distributed between the parenchymatous and the interstitial, occurring in the former in 12 per cent. and in the latter in 13 per cent.

In the chronic interstitial nephritis hypertrophy of the heart without valvular disease was met with in 27 per cent. of all cases, while in the parenchymatous form it was 34.5 per cent.

Hypertrophy of the heart with valvular disease co-existed with chronic interstitial nephritis in 42 per cent., or nearly twice as frequent as in the parenchymatous forms, in which it was 23 per cent. (occurring with equal frequency in the large white, and fatty and contracted kidney).

The degree of hypertrophy appears also to be influenced by valvular disease, and still more by pericarditis, as the following results will show:

Cases.	Average weight of heart.
Hypertrophy without valvular disease 93	14 ounces
Hypertrophy with valvular disease 94	17 "
Hypertrophy with pericarditis 22	18 "

¹ The cases of parenchymatous nephritis recorded in the tables, it will be remembered, all belong to the *chronic* form save fifteen cases, which are of *acute* Bright's disease. These few cases appear, moreover, nearly in equal proportion in the two series, so that a comparison may be fairly made.

² There were five cases among the Hospital records of red granular kidney, in which the cause of death was designated as *senility*. As there were many aged persons among the autopsy material of this series, I fear that some more cases of senile atrophy of the kidneys with absence of hypertrophy of the heart have crept into these records. This would explain the discrepancy in the statistical results, viz., 60 per cent. of hypertrophy in the Hospital cases to 92 per cent. in my own cases (in red granular kidney).

The duration of the disease and the age of the patient are evidently probably correlative with the degree of the hypertrophy.

As to the special forms of valvular disease the following table is of interest:

VALVULAR DISEASE.							
CORONER'S CASES.	AORTIC.	MITRAL.	DOUBLE.	TOTAL.	CORONER'S CASES.	AORTIC.	MITRAL.
Parenchymatous 100 cases,	12 per cent.	12 per cent.	5 per cent.	29 per cent.	Parenchymatous 75 cases.	7 (9% per cent.)	14 (18% p. cent.)
Interstitial 50 "	12 (24 per cent.)	4 (8 per cent.)	7 (14 per cent.)	23 (46 per cent.)	Interstitial 75 "	14 (18% p. cent.)	20 (26% p. cent.)
HOSPITAL CASES.	AORTIC.	MITRAL.	DOUBLE.	TOTAL.	HOSPITAL CASES.	AORTIC.	MITRAL.
Parenchymatous 75 cases.	7 (9% per cent.)	14 (18% p. cent.)	10 (13% p. cent.)	31 (41% p. cent.)	Parenchymatous 75 cases.	7 (9% per cent.)	14 (18% p. cent.)
Interstitial 75 "	14 (18% p. cent.)	20 (26% p. cent.)	9 (12 per cent.)	43 (57% p. cent.)	Interstitial 75 "	14 (18% p. cent.)	20 (26% p. cent.)
					VALVULAR: GRAND TOTAL OF ALL CASES.		
					In Parenchymatous,	24 per cent.	
					In Interstitial,	53	

The average weight of the hypertrophied heart appears from my tables to be as follows in the different forms of Bright's disease:

Average weight.	
In acute Bright's disease	10 ounces.
In large white kidney	15 "
In fatty and contracted kidney	14 "
In red granular kidney	17 "

RELATION OF THE WEIGHT OF THE BODY TO THE WEIGHT OF THE HEART.

That the former has a great influence upon the apparent degree of the hypertrophy of the heart, may be gleaned of the table that I submit below, in which the important factor, the weight of the body expressed in periods, is considered side by side with the weight of the hypertrophied heart.

Jan. 4, 1890.

Communications.

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TABLE SHOWING RELATION OF WEIGHT OF
HEART TO THAT OF BODY.

Weight of the heart as found.	Large white kidneys, in- cluding 10 cases acute Bright's disease (54 cases).		Fatty and contracted kidneys (46 cases).		Red granular kidneys (50 cases).	
	Number of cases ob- served.	Average weight of the bodies.	Number of cases ob- served.	Average weight of the bodies.	Number of cases ob- served.	Average weight of the bodies.
Below 10 ounces. .	13	132	3	120	1	190
10-11 " .	5	128	7	130	2	155
11-12 " .	2	134	2	135	2	110
12-13 " .	6	148	4	130	3	130
13-14 " .	5	152	4	134	4	120
14-15 " .	3	138	4	132	..	..
15-16 " .	1	145	5	130	6	143
16-17 " .	3	157	2	140	7	122
17-18 " .	..	..	3	146	5	135
18-19 " .	4	151	2	142	..	..
19-20 " .	3	150	1	130	4	138
20-25 " .	9	150	7	152	11	142
25-30 " .	..	..	2	160	5	163

It will be seen from this that advanced degrees of hypertrophy, viz., the heart weighing above 15 ounces, occurred as follows:

	Cases.	Per cent.
Acute Bright's and large white kidney—heart above 15 ounces	20	37.5
Fatty and contracted kidney—heart above 15 ounces	22	48
Red granular kidney—heart above 15 ounces	38	76

Where there were large hearts, as a rule, valvular disease co-existed, especially when associated with the red granular kidney. Also, with few exceptions, the largest hearts corresponded more or less with the largest sized bodies.

MICROSCOPY OF THE HYPERTROPHIED
CARDIAC MUSCLE.

There are two points of interest in regard to the microscopical appearance of hypertrophied heart muscle in Bright's disease that I will briefly refer to:

1. Cardiac hypertrophy depends upon simple increase in the bulk of the muscular fibres, viz., a simple, true hypertrophy, and not upon any hyperplasia (increase in number) of the elements. Each individual muscular fibre in the hypertrophied heart shows by accurate micrometry to be two or three times thicker and longer than the normal muscular fibre of the heart; and it is, therefore, not surprising that the latter should become twice or three times enlarged. The

hyperplasia of the connective tissue, though quite marked in many specimens, is not an important factor in adding to the bulk or weight of the heart.

2. Necrotic change of the muscular fibres was occasionally observed in some of the largest hearts, especially in limited areas. Yet in many instances this proved to be due to cadaveric change, which I need not explain at this place. I refer to this, only because in some instances it may be mistaken for true ante-mortem fatty metamorphosis of the cardiac muscle.

FATTY METAMORPHOSIS OF HEART.

In the 300 cases of Bright's disease tabulated in this paper fatty metamorphosis of the heart was found to be present in only 26 per cent.; it being absent in 74 per cent.

The distribution of fatty metamorphosis of the hypertrophied cardiac wall in the several forms of Bright's disease proved to be as follows:

Series A—Coroner's and Private Cases.

	Cases.	Per cent.
In the large white kidney	8	18
In the fatty and contracted kidney .	15	33
In the red granular kidney	25	50
Fatty metamorphosis, absent or not stated	102	68
Fatty metamorphosis without hypertrophy	16	11
Total of fatty metamorphosis . . .	48	32

Series B—Philadelphia Hospital Cases.

	Cases.	Per cent.
In acute Bright's disease	1	20
In the large white kidney	5	14
In the fatty contracted kidney . .	8	23
In the red granular kidney	17	23
Fatty metamorphosis, absent or not stated	119	79
Fatty metamorphosis, without hypertrophy	20	13

Grand Total.

	Cases.	Per cent.
Fatty metamorphosis, present . . .	79	26
Fatty metamorphosis, absent	221	74

While it appears that fatty metamorphosis of the heart muscles co-exists more frequently with the red granular kidney, I found that in many of these cases the necrotic change of the muscle was but slight, whereas in conjunction with the fatty and contracted kidney and in some non-hypertrophied hearts it was decidedly more pronounced. The typical brown atrophy of the heart occurred in my cases more commonly in the fatty and contracted kidney, at advanced age and coincident with atheroma of the coronary arteries. The pigmentation around

the nuclei of the muscle is also most conspicuous in these cases.

Fatty metamorphosis whenever met with was fairly indicated by the dilatation of the cardiac walls and distinct yellow or brownish striations beneath the endocardium and particularly in the *columna carnea*; occurring with equal frequency in the right and left chambers.

The method adopted for microscopical examination was an easy one, and the best, viz., teasing in salt water or weak caustic soda solution; nearly every suspicious heart of Series A was examined while fresh, with the results stated in the records. Fatty infiltration and cirrhosis of the interstitial tissue of the cardiac walls was met with in six cases, combined with fatty metamorphosis.

ARTERIAL CHANGES.

Atheroma of the aorta and some of the larger vessels was observed as follows:

Series A—Coroner's and Private Cases.

	Cases.	Per cent.
In the large white kidney	12	27.5
In the fatty and contracted kidney	29	63
In the red granular kidney	45	90

Series B—Hospital Cases.

	Cases.	Per cent.
In the large white kidney (including one of acute Bright's disease)	10	23
In the fatty and contracted kidney	13	37
In the red granular kidney	48	64
Total in both series	157	52

Endarteritis and periarteritis of the renal vessels were studied only in Series A, and showed:

	Cases.	Per cent.
In the large white kidney	3	7
In the fatty and contracted kidney	4	8
In the red granular kidney	41	82

It should be further noted that whereas the first two of these kidney lesions revealed but slight arterial changes, the red granular kidney showed them well pronounced.

Arterial changes, it is seen, come prominently into consideration only in one form of Bright's disease, viz., the red granular kidney, forming only a small portion of the total histological picture of it. It is not my object in the present paper to go into the consideration of this question. I may state, however, that Gull and Sutton in their excellent and original work, "On the Pathology of the morbid state commonly called Bright's Disease" (*Medico-Chirurgical Trans.*, vol. lv, p. 273), appear to have referred exclusively to the primarily contracted kidney when they brought forward

their famous theory of "Arterio-capillary Fibrosis." Some of the latter writers on this subject, however, erroneously attribute all forms of Bright's disease to primary vascular changes.

Histological studies in this direction are being conducted, and have been for some time past, in my laboratory by several gentlemen. The results of these investigations, I believe, will prove interesting when published.

COMPLICATIONS.

The prominent complications and concurrent affections other than those already given in my tables, some of which co-operated in the immediate causes of death, are distributed in the 300 cases of Bright's disease as follows:

Hydrothorax 53, pleurisy 40, emphysema 32, peritonitis 21, syphilis 27, alcoholism 18, puerperal diseases 14, tuberculosis 13, meningitis 13, septicemia 12, cirrhosis of liver 11, bronchitis 10, ether narcosis and surgical operation 9, erysipelas 8, gastric cancer 8, aneurism 7, senility 5, cancer of various parts 4, gastric ulcer 4, typhoid fever 3, gangrene 2, scarlatina 2, burns 1, etc. Often two or more of these conditions co-existed.

AVERAGE WEIGHT OF KIDNEYS IN BRIGHT'S DISEASE.

The average weight of the kidneys in the various forms of Bright's disease is of interest and is as follows (in ounces):

	Right.	Left.
Acute Bright's disease	7.65	8.12
Large white kidney	6.91	7.87
Fatty and contracted kidney	4.74	4.86
Red granular kidney	3.13	3.43
General average of	5.61	6.07

MORTALITY OR DURATION OF LIFE IN BRIGHT'S DISEASE AS SEEN FROM THE 300 CASES TABULATED.

SERIES A.—PRIVATE AND CORONER'S CASES

	10-20 years.	20-30 years.	30-40 years.	40-50 years.	50-60 years.	60-70 years.	Over 70 years.
Acute Bright's disease	3	2	3	2	0	0	0
Large white kidney	4	15	17	6	1	1	0
Fatty and contracted kidney	0	4	2	14	12	3	1
Red granular kidney	1	4	5	5	16	15	4

SERIES B.—PHILADELPHIA HOSPITAL CASES.

Acute Bright's disease } and large white kidney.	4	6	12	7	5	1	1
Fatty and contracted } kidney.	1	1	7	7	7	7	4
Red granular kidney . . .	0	3	4	16	17	18	17

SEX AND AGE.

PRIVATE CORONER'S CASES.	No. of cases.	Percentage of		Average age in both.
		Males.	Females	
Parenchymatous forms of } nephritis	100	58 p. c.	42 p. c.	35 yrs.
Interstitial nephritis	50	68 p. c.	32 p. c.	52 yrs.

PHILADELPHIA HOSPITAL CASES.				
Parenchymatous forms of } nephritis	75	69 p. c.	31 p. c.	43 yrs
Interstitial nephritis	75	52 p. c.	48 p. c.	59 yrs.

I admit that as regards many interesting details these studies, as now presented, are deficient. I propose to complete them in the future with such additions as the continuous new supply of material will offer.

The literature on these subjects is very interesting, but I shall not take up space with matters well known to the reader.

EXSECTION IN A CASE OF OLD FRACTURE OF THE BASE OF THE RIGHT RADIUS.¹

BY J. S. WIGHT, M. D.,

PROFESSOR OF OPERATIVE AND CLINICAL SURGERY AT THE LONG ISLAND COLLEGE HOSPITAL.

On November 29, 1886, A. H., a seaman, twenty-seven years old, fell fifteen feet, striking the palm of his right hand on a plank floor, and breaking the radius just above the wrist-joint. There was much deformity. According to the statement of the patient, he was conveyed to a hospital, where he was under treatment ten weeks, after which he was discharged, with great deformity and disability. In about a week

¹ Read before the Brooklyn Surgical Society, October, 1888.

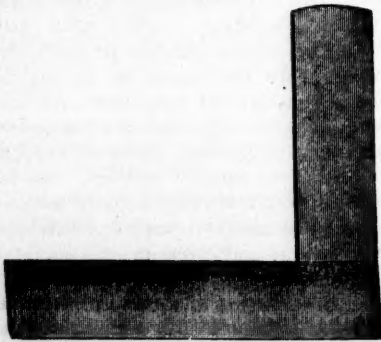
after this he was admitted to another hospital, where he was treated for two months and three days, when he was discharged without any visible improvement.

On September 5, 1887, this patient was brought to my office, to see if he could be relieved from his pain, deformity and disability, to an extent that would enable him to support himself. I found an ancient fracture of the base of the right radius. The lower fragment of the radius was nearly three-fourths of an inch in length, and had a complete lateral displacement backward. The lower end of the upper fragment of the radius, having a forward lateral displacement, was pressing firmly against the flexor tendons in front of the wrist. The longitudinal displacement was nearly as great as the length of the lower fragment, so that the wrist appeared to be much enlarged. The radial side of the hand was considerably rotated outward, giving the ulnar side the appearance of rotation inward. The hand and the lower fragment of the radius were dislocated backward from the distal end of the ulna, which was very prominent, forward and inward, adding much to the deformity. The fingers and hand were in a position of flexion to some extent. There was some fibrous union between the fragments, leaving a new point of motion. The motion at the wrist-joint was greatly impaired. And the rotation of the forearm had been abolished. The radial artery could not be found, and had probably been obliterated by the injury or by pressure. The hand was not well nourished; the interosseous muscles were very much atrophied. When in a dependent position, the hand and wrist were greatly swollen. In fact, there was very considerable deformity, accompanied by almost complete disability of the right hand and forearm.

At the time I saw this case, reduction of the hand and the lower fragment of the radius was impossible. At the time of the accident they may have been irreducible. Or being reducible it may have been impossible to keep them in place. Three questions arose in my mind: Shall I let the patient alone, and leave him to get such use as he can out of his injured limb? Shall I amputate the hand, so that he can do something with the one that is left? Shall I exsect the wrist in such a way as to give him some use, however small, of his now disabled right hand? I could not conclude it best to let the patient remain as he was; nor

did I think it right to amputate the hand, though such an operation might in time be required. The best opinion I could form was that a resection ought to be performed. So I proposed and advised, and the patient accepted my proposition.

The patient was then admitted to the College Hospital, where I operated on his wrist, before the medical class, in the following manner: An incision three inches in length was made over the lower end of the ulna, so as to permit the thorough exposure of the bone. A little more than an inch of the distal end of the ulna was removed with a saw. The hand was then forcibly abducted, and the union between the radial fragments was severed. The lower end of the upper radial fragment was then exposed and sawed off even with the cut end of the ulna. The greater part of the lower radial fragment was then removed through the opening already made on the inner aspect of the wrist. Then an incision about two inches in length was made between the extensor primus and the extensor secundus of the thumb. The extensor carpi radialis was drawn aside, so as to give room for the removal of the rest of the lower fragment of the radius. The wound was dressed antiseptically, and the limb was put on my double-angled splint. This splint has an armpiece which meets the forearm piece at



two angles. The longitudinal axis of the armpiece meets the longitudinal axis of the forearm piece at a right angle, and the transverse axis at an obtuse angle equal to the angle at which the long axis of the arm meets the plane of the forearm. The splint is shown in the accompanying illustration.

The position of the hand was good, and there was no difficulty in keeping the parts in place. The drainage-tube was not removed until the end of four weeks. There

was considerable inflammation which continued for some time after the operation, and the repair took place slowly, as if the blood supply was defective. The patient was discharged from the hospital in April, 1888, in an improved condition. Some weeks after a few small pieces of necrosed bone came away. It may be remarked that passive motion was made from day to day during his stay in the hospital.

In July, 1888, I saw this patient again, and made the following observations: The right hand was atrophied, being smaller than the other; the fingers have considerable flexion, and the thumb could be voluntarily brought in contact with each of them. The motions of the new joint were nearly one-fourth as great as those of the opposite side, while the rotation of the forearm had been completely lost. The limb was still improving and becoming stronger. The hand was quite useful having considerable prehension; he could pick up and hold small objects with much facility. There was a great gain over what I first found, when he came to me, and when he was entirely helpless. Subsequently this patient obtained light employment, in which he did not have to lift heavy objects, and was thus able to earn his own living.

MESSAGE IN THE TREATMENT OF SPRAINS.

BY MASSEUR KURRE W. OSTROM,
FROM THE ROYAL UNIVERSITY OF UPSALA, SWEDEN.

It is becoming well recognized that massage is of the greatest value in the treatment of sprains, both acute and chronic. The sooner the parts affected are subjected to manipulations, the more rapid the results will ensue.

In beginning, the parts are of course very tender, and no other manipulation should be used than the slight superficial *stroking*, performed by the tips of the fingers or the palm of the hand, and after only from ten to fifteen minutes treatment a decrease of the swelling will be easily noticed. The two or three first treatments should consist only of this centripetal stroking and last no longer than fifteen minutes. As soon as the most acute pain has disappeared, *friction* should be applied, a circular manipulation being performed with the tips of the fingers upon the parts, the aim of this is to force

out deposits from the affected parts, and to distribute them through the surrounding tissues. Every friction should be followed by centripetal strokings, the whole treatment being performed within twenty-five minutes. Dr. Murell says: "After a few treatments the pain, the discoloration, and the swelling disappear as if by magic." The treatment should be applied twice daily, if possible. After the third treatment the movement of the ankle joint is quite free and almost painless. The patient may then be allowed to take a few steps, and if the pain does not recur, the amount of exercise should be increased every day. After each *séance* the ankle should be bandaged with flannel. A water application at night will materially assist the treatment. At the end of the fourth or fifth treatment a few Swedish movements, such as flexion and extension, turning, and rotation of the foot, are to be recommended.

In severe sprains, when there is a rupture of a ligament or a tearing off of the bony parts, the massage treatment is generally contra-indicated; still a careful and educated masseur can greatly assist the surgeon to reduce the swelling and thus make the location of the injury more accessible to him.

Why should we prefer massage treatment before any other remedy for sprains? Simply because the records of cases of sprains treated by massage show that we get better results by this plan of treatment and that we also obtain cures in a much shorter time. Philippeaux says that a slight recent sprain is cured in one sitting, and in severer sprains he has found four to five treatments to be sufficient to put the patient on his feet again. This is no doubt very true, but how much use has the patient of his injured foot after only four or five treatments? Mullier found that the average number of days required to cure sprains by the old way (immobilization and dressings) was 25, while by the massage treatment the average was only 9. Dr. Douglas Graham, the most skillful masseur of America, found that, in several hundreds of cases of sprains and similar affections, the average time needed for recovery was 9 days.

In Germany, where sprains are especially common in the army, massage is exclusively adopted as the only proper treatment.

Some of the most prominent physicians advocate massage as the proper treatment for sprains, and it ought not to surprise any one

that they advocated this treatment, when it is a well-known fact that it takes less than half the time to make a complete recovery by this plan as is required with any other. I am perfectly satisfied that the massage treatment for sprains, as well as for many other affections, would be more universally adopted by the medical profession, were it not for the many uneducated "rubbers" who are now so common in the larger cities, claiming to cure anything and everything with a treatment, called by them by the scientific name of "massage," although practically they give nothing but a superficial rubbing, which by no means is massage, and they are apt to do more harm than good, as they generally have no knowledge of the anatomical structure of the parts.

250 North 15th Street.

REST IN THE TREATMENT OF PULMONARY CONSUMPTION.

BY THOMAS J. MAYS, M. D.,

PROFESSOR OF DISEASES OF THE CHEST IN THE PHILADELPHIA POLYCLINIC.

About a year ago I delivered two lectures in the Philadelphia Polyclinic evening course, entitled: *Pulmonary Consumption considered as a Neurosis*,¹ in which I gave expression to a view which had been gradually growing on me during previous years concerning the true nature of pulmonary consumption. In these lectures I formulated my belief that this disease could no longer be regarded as a local inflammation of the lungs but that it must be looked upon as an affection the fundamental lesion of which is a disease of the pneumogastric nerves. Imperfectly as this view was put forth, I had the conviction that it rested on a solid basis, and I have since then investigated the question from every available standpoint, the results of which will be published in book form so soon as I will be able to put the material into proper shape. I will merely say that my earlier idea has been fully confirmed by these later researches, and that the neurotic theory furnishes the only rational explanation of the beginning, the course and termination of pulmonary consumption.

¹ See *Therapeutic Gazette*, Nov. and Dec., 1888; also *Medical News*, May 25, 1889.

Towards the close of the last lecture I said "if we view pulmonary consumption as a neurosis, it is very obvious that, *in order to be consistent in practice*, it is necessary to remodel and revolutionize some of our ideas concerning the treatment of this disease. This part of my subject is so comprehensive, however, that the limited time forbids me to do more at present than merely to touch the most salient points involved in this question. Briefly, I may say it has been established beyond doubt, and that, too, chiefly through the excellent practical researches of Dr. S. Weir Mitchell, that rest, absolute or an approach to it, is one of the most vital factors in the successful treatment of serious nervous diseases. But the idea of rest is contrary to the orthodox methods of managing consumption. Custom has handed down from time almost immemorial, the dictum that exercise is the one indispensable consideration in its treatment, and I apprehend that, on account of this universal impression, the recommendation which I am about to make will be received with a feeling of cold indifference, or, perchance, with opposition. Notwithstanding these risks to which I expose myself, I am constrained to say in the interest of truth so far as I am able to see it, that I believe the prevailing opinion that consumptives must have plenty of exercise is one of the greatest stumbling-blocks in the successful management of this disease. So deeply rooted is this idea in the mind of the public, that patients persist in walking until their vital energies are completely exhausted, when they give up, go to bed, and usually to die."

Exercise is undoubtedly beneficial to those who are strong already, but I contend that it weakens those who are weak already as much as it strengthens the strong. Probably this whole question can best be practically and briefly illustrated by taking an example from the field of finance. It is an old and true saying that money makes money. A man who has a certain amount of capital can make money much more easily than he who has none or very little. If the latter spends as much as he takes in, his finances will be in a crippled condition all his life; but if he halts,—that is, if he diminishes his outflow, and maintains, or increases his former income,—his capital will accumulate, and in time he will be able to compete with other capitalists. So the taking of exercise, which is to be beneficial, implies pre-existing strength, and by

putting this strength out at proper interest or to proper use it will grow and accumulate; but he who has no or very little strength at the outset, must reduce his expenditure and enlarge his income, or else he will go into physiological bankruptcy. It has well been said in an editorial on the subject contained in the *MED. AND SURGICAL REPORTER* of September 7, 1889 (p. 273), that "the consumptive may be regarded as verging towards a state of physiological bankruptcy. The disease makes a fatal drain on his constitutional resources. With him it is a real living warfare between the forces of his body and those of the disease. The line which divides defeat from victory is neither hard nor fast, but constantly shifts its position in accordance with the ebb and flow of his vitality. When he is weak the disease advances, and when he is strong it recedes. The cardinal therapeutic indications are therefore towards a fortification of the constitutional resistance. This can only be accomplished by economizing the bodily forces; and physiological rest is one of the most valuable adjuvants in securing this end."

So far as I am aware, Dr. Weir Mitchell was the first to demonstrate the value of rest in the treatment of phthisis more than ten years ago. He says:¹ "I have ventured, without much hope, to treat three cases of phthisis in the same manner (*i.e.*, with rest, massage, electricity, and feeding). There are cases of this nature in which exercise wearies. One of the cases treated got well and remained well. There was every evidence of pulmonary trouble. No. 2 improved enormously in all respects, and relapsed hopelessly, owing to large and repeated bleeding from piles and rectal fissure. No. 3, a male, 24 years old, was treated by rest and massage, without electricity, and improved so as to resume his work."

As a practical illustration of the value of rest in consumption I now beg to submit the histories of the following cases which have been treated in accordance with the principles advocated in the previous pages.

Case I. B. L., male, aged 30, an accountant, was first seen Oct. 24, 1887. He had been coughing for four years, had hæmoptysis the previous May after playing base-ball. He had lost flesh, but his appetite was fair, and his tongue clean; he had

¹ *Fat and Blood*, page 93.

malaria but no rheumatism, and complained of dyspnoea on exertion. There was no venereal history present, and no phthisical family taint. His temperature was about normal and his weight $137\frac{1}{4}$ pounds. The two preceding winters he had passed in Colorado and California. Physical signs: Impaired movement of left chest. Slight dulness in supra-clavicular and supra-scapular regions on same side. Crepitant and sibilant râles extending to interscapular region. Blowing inspiration over remainder of lung. Right lung normal. There were also found two brown blotches, one on each leg over the tibial crests.

He was treated with hot poultices over the right shoulder for four weeks, with compressed and rarefied air, pulmonary gymnastics and nutritious foods until the thirteenth of the following January when he weighed $139\frac{1}{4}$ pounds, and at which time the abnormal physical signs had almost entirely disappeared. His chest movements were more full and his inflation better especially over the affected apex, and although not entirely well he was on a fair road to recovery. At this time he went home and continued to improve. On March 17, he shoveled some snow off the roof, and this was followed within a few hours by the expectoration of some dark-colored blood, and by fever and aching pains of the body. During this slight attack he lost a pound and a quarter in weight, and the brown patches on his shins increased in size. In June he weighed 140 pounds, and at this time he resumed his vocation. He worked very hard, soon began to have a return of the achiness over his whole body, especially his back and legs, which was followed by a rise of temperature and in three weeks he lost seven pounds in weight. On the 10th of September I saw him again, when he weighed 125 pounds, and at this time a physical examination showed quite a profusion of moist râles in apex of left lung, together with some subcrepitation at base of same side. Shortly after this he again went to Colorado, and on his return, May 17, 1889, he called on me again, when he weighed 135 pounds. He informed me that during the first two weeks of his stay in the mountains he had had a good deal of difficulty in breathing, and that he also became very drowsy and was able to sleep at almost any time and in almost any posture. His cough and expectoration remained about the same, but the spots on his shins diminished in size.

His appetite was good, and his bowels regular. There was now dulness at base of left lung, anteriorly, laterally and posteriorly, and above this was a small area where a wavy respiration could be heard together with some friction sounds. The condition of the apex was very much as it had been at the previous examination. He placed himself once more under my care, because with all the gain in flesh he did not think his lung was as good as it should be. This view was also confirmed by the physical signs. Having become thoroughly persuaded concerning the practical importance of rest, from treating several other patients since I saw him last, I advised it and began to administer it at once. I did not compel him to go to bed, but ordered him to remain quietly in a sitting or lying position during the twenty-four hours. He rode out but walked very little. Internally I gave him phenacetin, quinia, potassium iodide, and oxygen with compressed air. From this time he improved in every respect. His cough and expectoration diminished, his appetite improved and he gained in flesh, while at the same time the physical signs changed for the better. In six weeks he gained nine pounds; his weight then being 144 pounds—four pounds more than he ever weighed in his life. I consider him practically well, although the dulness has not entirely vanished from the apex and base of the left lung.

This case more than ordinarily illustrates the value of rest in treating this disease. The trouble, according to the patient's own statement, began with hæmoptysis, which he brought on by playing base-ball, and the subsequent attack of blood-spitting was produced by shoveling snow, and if I had realized then as I do now the importance of keeping him quiet even after this setback, I do not believe he would have had the serious relapse which occurred the following summer. At this time he felt very well, and without any determined interference on my part he went to work, remained at it from early morning until late at night, and in less than two weeks he lost all and more than he had gained before. The same mistake was made here that is made so often in similar instances. It is a common experience that consumptives get along admirably so long as they lead a more or less inactive life; but in consonance with the prevailing belief that they must have physical exercise and fresh air in order to be fully

restored they are led to over-estimate their strength, go to the work which has waited for them so long, and often with the most serious consequences to themselves. A good rule to follow in such cases, I have since learned, is not to allow a patient to take much exercise even after he is considered well enough to undertake it, unless he becomes accustomed to it gradually.

An interesting feature in this case was the peculiar history of the brownish discolorations on his shin-bones. According to his account these dated from the beginning of the lung trouble. On several occasions I observed that the area of these spots moved in harmony with the state of the lung and with his general condition, *i. e.*, if he became worse the spots increased in size, and their centres seemed more dense and angry looking; while, if he improved, the spots became smaller and finally disappeared almost entirely. These oscillations undoubtedly show that there was some connection between these spots and the state of the chest—both probably depending on a still deeper lying, common basis, *viz.*: the general nutrition of the body.

Case II. T. Y., aged 34, a brick mason, was first seen June 21, 1888. He had been well until the previous January, when he had a chill which was followed by fever, cough, and an expectoration which was yellow in the morning. Spat blood about six weeks before he came for treatment. He was hoarse occasionally, had never had malaria, rheumatism, or specific infection. His appetite was poor, tongue coated, and he felt tired continually. He is the oldest of a family of eight children, three of whom died of infantile diseases, and two sisters respectively. His father and mother are well. He had an evening temperature of 101° , and his weight was 143 pounds.

Physical signs. Slight dulness in left apex associated with crepitant and sibilant râles. Some moist râles distributed over his whole chest. He was treated with antifebrin, quinia, hypophosphites, poultices, pulmonary gymnastics and inhalations of compressed air, until the 31st of July, when both symptoms and physical signs had materially improved. His evening temperature was 99° , and he had gained one pound and a half. The poultices were discontinued. At this time he changed his boarding place, which compelled him to walk some distance four times a day to the place where

he obtained his compressed air. He soon began to feel tired and languid, became restless at night, had a perceptible rise in temperature, a slight loss of flesh, and an impaired appetite. After this he was kept quiet and then made an almost uninterrupted recovery, and in seven months from the last date he weighed 160 pounds. He still maintains this weight and has been at work for four months.

Case III. H. T. was first seen Nov. 22, 1888, when he had had a cough and copious expectoration for a year; felt chilly; had night-sweats; a poor appetite, and a temperature of $101\frac{1}{2}^{\circ}$ in the evening. His weight was 142 pounds. Physical signs: dulness, crepitation, and wavy respiration in upper half of left lung.

Internally he was ordered antifebrin, quinia, strychnia, and atropine, and externally a flax-seed meal poultice to left lung. He was kept quiet, and in a few days there was a perceptible improvement in his condition. His temperature declined to $99\frac{1}{2}^{\circ}$ in two weeks; his appetite became good, and he gained in strength. During the first few weeks when he was poulticed he was kept on his back principally, afterwards he was allowed to sit up, but not to walk much. The following 10th of January he weighed 157 pounds; the physical signs had disappeared, and he felt well and has been working ever since.

Case IV. S. J., aged 22, was first seen May 4, 1889, when he gave a history of cough and expectoration for several years. He had several attacks of hæmoptysis, also chills, fever and night-sweats; his appetite was poor, and his temperature in the evening was 104° ; his weight being 127 pounds. Physical examination showed a good-sized excavation with consolidation around it in the upper portion of right lung, together with crepitation in same region; mucous râles were discernible on opposite side. He was placed at rest immediately, given phenacetin internally in four-grain doses every four hours, and a poultice was applied to the chest. He had been taking cod-liver oil and this was continued. At first he did not do well. His rigors became very pronounced and his temperature fluctuated from 104° one day to 96° the next. Phenacetin even in ten-grain doses did not fully control these variations. It was exchanged for antipyrin in seven-and-a-half-grain doses every four hours with the most desirable results. In three weeks his temperature became more

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stable and has remained at about 99° ever since, with the exception of a few days when he neglected to take his medicine, it rose to 100°. He has gained in appetite, strength and flesh until now he weighs 136 pounds, and would be willing to take active exercise if I gave him permission.

I think these cases, which are extracted from my private record-book, illustrate very emphatically what rest combined with other appropriate treatment is capable of accomplishing in this disease. Of course, such highly favorable results are not to be expected in every instance, for I could relate the record of cases which terminated disastrously, yet I am certain that the examples here given represent the results which can be gotten in the great majority of consumptives which present themselves for treatment.

1829 Spruce street.

CREMATION.

WHAT IS THOUGHT OF IT BY PHYSICIANS.

INTERVIEWS WITH PHYSICIANS BY A REPRESENTATIVE OF THE MEDICAL AND SURGICAL REPORTER.

THIRD SERIES.—PHILADELPHIA.

DR. S. WEIR MITCHELL is decidedly in favor of cremation. He would desire the cremation of his own mortal remains, were it not in opposition to the wishes of his family. Although he has not given the subject much thought, Dr. Mitchell is of the opinion that incineration is unquestionably a superior method for the disposal of the dead than inhumation. Regarding the question of ground pollution, he is not willing to offer any opinion, not having given the subject any study whatever.

DR. W. W. KEEN expresses himself as entirely in accord with the introduction of cremation into this country. He thinks that the custom is gradually but steadily gaining ground; as indeed it should, since the arguments in its favor entirely overbalance anything that could be said against it. Hygienically its most bitter opposer cannot fail to see its superiority over inhumation. Ethetically, if rightly understood, there is nothing loathsome or disagreeable about the

custom, but, to his mind, it is far more refined and beautiful than burying. Personally, Dr. Keen desires to be cremated. He expects and hopes that the practice will increase in favor in the United States, and may, ultimately, become universal.

DR. CLARA MARSHALL favors cremation both hygienically and sentimentally. She fully believes in ground pollution and opposes burials on the banks of the rivers, which furnish city water-supplies. She personally has no aversion feeling towards cremation and would gladly assist in its promotion. Dr. Marshall thinks that many will oppose the custom for theological reasons.

DR. HARRISON ALLEN favors the promotion of cremation, especially from a sanitary point of view. Regarding the question of ground pollution, Pasteur has proved the contamination of the ground through the interment of dead bodies to be possible beyond all doubt. The introduction of cremation would be a great boon to the public health. He thinks, however, its adoption in this country will be a slow matter. It is next to impossible to change the customs or rituals of a people. This is especially the case with regard to the disposal of the dead. The Chinese go as far as to ship all their dead back to their native land for interment, and have numerous quaint superstitions that centuries have failed to remove. The Alaska Indians have also very strong feelings in this matter, and look upon desecration of the dead as a crime worthy of punishment by death. Similar feelings, although perhaps of less marked degree, based both upon sentimental and religious grounds, are naturally aroused within us when any change of rite or custom is urged. Personally Dr. Allen has no objection to cremation and is convinced of its great hygienic value.

DR. H. C. WOOD thinks the question one of but very little moment. Whether it be introduced or not, he says it does not amount to a row of pins. The custom is entirely a matter of individual taste. For his own part he has not the slightest interest in what became of his own body. Regarding ground pollution, he did not believe in it; and does not all mind drinking the filtrations of, or eating the products of the remains of his ancestors. He considers cremation an unnecessary procedure.

DR. D. HAYES AGNEW does not think that the time has yet come when cremation is necessary for the good of the public health:

At present the country is not so densely populated as not to leave ample room for interments at good distances outside of city limits; and this will be the case for a long time to come. Dr. Agnew deprecates burials near city water-supplies, such as in our Laurel Hill Cemetery, stating that these very probably lead to a contamination of the water. True, this proposition has been denied, it being claimed by some that all organic matter is filtered out by the ground and that only innocuous fluids reach the stream. This hypothesis has, however, by no means been proved; and our riverside burial places must still be regarded as possible sources of danger to the public health. City burials are without doubt most unsanitary; this is especially the case with pauper burials, where the graves are allowed to remain open until filled with bodies, or where the bodies are buried in trenches which are not filled in until full of coffins. Similarly burials in wet ground may be regarded as sources of ground pollution. Dr. Agnew considers the cremation of the remains of persons having died with infectious or contagious diseases both proper and necessary. Still, he urges, there is no longer any reason why infectious diseases should at all exist, since our knowledge of their origins and our understanding of sanitation and prophylaxis of disease has become so broadened. He would therefore rather look forward to the day when the introduction of cremation should no longer be necessary, on account of the extermination of infectious or contagious diseases, due to the strict enforcement of sanitary laws; rather than to contemplate the fact that, on account of poor sanitation and over-crowded burial grounds, cremation should have to be enforced for the sake of the public health. From a hygienic standpoint, there are other sanitary laws and regulations the strict compliance with which is, at present, more necessary than the introduction of cremation. Individually every one should have the right to provide for any desired disposition of his or her own remains. Esthetically Dr. Agnew sees nothing against cremation. On being questioned as to the disposition of his own body, Dr. Agnew at first expressed himself as entirely indifferent, but, after a moment's reflection said that he would rather be buried, confessing, however, that the wish was merely sentimental.

DR. SAMUEL D. RISLEY favors cremation from a hygienic point of view; considering it superior to our present methods of dis-

posal of the dead. City burials as well as inhumations on the banks of streams furnishing city water-supplies are, without doubt, unsanitary, and sources of danger to the public health. Still, he believes that the system of inhumation could be made to comply with all sanitary requirements, were the burial places removed well out of the city. In this country there is ample ground, and contiguous cemeteries are unnecessary. So long as this is the case the universal adoption of cremation is not called for. In speaking from sentiment, Dr. Risley confesses a certain aversion to cremation, due, undoubtedly, to early education and usage; yet should he have to choose between city burials and cremation, he should unhesitatingly decide in favor of the latter.

DR. WILLIAM PEPPER expresses his opinion as follows:

"I am strongly in favor of cremation, and believe that in the future this mode of disposition of the organic portions of dead bodies will be generally adopted.

"Hygiene teaches clearly the danger of burying such bodies, laden with the germs of disease which will develop and multiply so long as any organic matter remains; and which may find their way by currents of water into springs or streams used for drinking purposes.

"Sentiment revolts at the contemplation of such slow, grewsome processes, or at the employment of rapidly destructive agents like quick lime, as much as it does at the thought of subjecting the bodies of our loved ones to the action of fire, the supreme purifier, which will drive off, in harmless form, the organic portions, and enable us to retain in a permanent and unobjectionable state their ashes."

—There are 21 Universities in Italy, 17 royal and 4 provincial. The former are arranged in two classes, 10 belonging to the first and 11 to the second. The Universities are very unequally distributed throughout the kingdom, Sicily having 3, Sardinia 2, the States of the Church 7, while the Kingdom of Naples, Piedmont, and Venetia have only 1. The one most frequented is that of Naples, which has 3,900 students; then comes Turin with 2,100, Rome with 1,200, Bologna with 1,160, Padua and Pavia with 1,000 each, and Palermo with 950.

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Typhus.

Professor Hlava has published in a Bohemian medical journal, an account of a severe typhus epidemic which raged in Prague last year. Altogether about 400 cases occurred, of which forty-five proved fatal. Professor Hlava was able to make observations on the blood of most of these. He found in many of them a special microbe, which he regards as a streptococcus, existing in the blood; and the same microbe was found in two instances in the blood of patients during life, but it was never detected in the intestines. When cultures of this micro-organism were injected into rabbits they became feverish, but the affection was evidently of a totally different character than typhus fever in the human subject. It is therefore not possible to say whether or not this streptococcus is the cause of typhus. Regarding the way in which infection is transmitted, Professor Hlava is disposed to think that it is not through the air or by means of water that the disease spreads, but rather by direct contact.—*Lancet*, Dec. 7, 1889.

Uterine Cancer in Monkeys.

At the meeting of the Pathological Society of London, held Dec. 3, Messrs. Bland, Sutton, and Gordon Brodie made the following communication. For some time past they had been accumulating material for an investigation of cancer, especially in connection with the uterus. It appeared that uterine cancer, though so very common in the human female, was rarely met with in other mammals, and was hardly known to veterinary surgeons. This induced them to commence the investigation by a study of the cervix uteri in monkeys, in order to ascertain if any anatomical conditions existed favoring the development of cancer in human females. A few years ago one of them exhibited before the Society a series of specimens demonstrating that monkeys (macaques and baboons) living in confinement in this country were liable to uterine flexions. Subsequently, evidence was given before the Gynecological Society that macaques and baboons menstruated after the same fashion as women. The inquiry was followed up, and it was found that the menstrual period

in these monkeys was very variable. In some it lasted a longer time than in others, whilst now and then a monkey appeared in an almost chronic state of menstruation. In many the menstrual period was followed by profuse leucorrhœa. Normally, the discharge of blood lasted from one to two days, but the redness of the less hairy parts persisted as long as a week. The average interval between each menstrual period was difficult to fix with accuracy, as it varied from a month to six weeks, or even longer; it was a safe inference, when a monkey menstruated two, three, or even four times a month, each attack lasting three or more days, followed by leucorrhœa, that the case was one of metrorrhagia. During the past summer a macaque was particularly watched; the metrorrhagia and leucorrhœa became so profuse as to render it unfit for exhibition, and, being of small money value, it was killed. The uterus was removed before the parts had lost their tissue life, and was found to be acutely retroflexed; the cervix enlarged, the os patulous, and a florid-looking mass projected from it, identical in appearance with what in gynecology is called an erosion. After hardening the parts sections were prepared for the microscope in such a way as to include the os externum, the cervical canal, and portio vaginalis. Under a low power the mass protruding from the os, as well as a polypoid mass some distance up the canal, resembled a cervical adenoma, and in structure identical with the glandular tissue held to be characteristic of erosions in women, the acini being apparently lined by columnar epithelium. Many of the most typical acini were filled with a singular, apparently homogeneous material. Under higher powers and careful illumination the supposed columnar cells were seen to be club-shaped, and in favorable sections the supposed glandular crypts turned out to be rosettes fringed with the clubs so characteristic of actinomyces. The clubs varied somewhat in shape, many of them fringing the rosettes with the greatest regularity. In other places they occurred in "banana-like bunches," especially when stained with fuchsin. The clubs surrounding the rosettes stained with difficulty. In some places a cluster of clubs had been cut transversely; in such, a characteristic mosaic was produced. They could not detect the filaments, but this was probably due to their lack of skill in staining methods, but a number of granular bodies presented themselves in vari-

ous parts of the section. Thus far the microscopic characters were consonant with actinomycosis. On examining the centre of the rosettes some distinctly rounded bodies caught the eye associated with clumps of epithelioid-looking cells; when these central bodies were critically examined they resolved into cysticeri, with the head and neck retracted. Whether their presence in the midst of the rosettes was accidental or otherwise would require further elucidation; as far as they had examined the sections, the cysticeri appeared to have some causative relation to the rosettes. Although Messrs. Sutton and Brodie wished at first to limit this preliminary statement to facts connected with monkeys, they could not refrain from observing that they had detected so far as the rosettes and clubs were concerned exactly analogous conditions in erosions from the human cervix uteri, and in a case of cancer of the cervix.—*Lancet*, Dec. 7, 1889.

Pruritus.

In the treatment of general cutaneous pruritus, Dr. Wertheimer, in the *Münchener Med. Wochenschrift*, Nov. 4, 1889, recommends a tablespoonful of a three per cent. solution of salicylate of soda, three times a day. This treatment will not only ameliorate the unpleasant symptoms of pruritus, but is said to completely eradicate the disease in a short time.

Creasote in Pulmonary Gangrene.

In the Moscow bi-weekly *Meditsinskoi Obozreniē*, Nov. 10, 1889, Dr. Draïtry L. Romanovsky, of Reval, writes that he has found creasote of excellent service in several cases of pulmonary gangrene, as well as in chronic putrid bronchitis, and in putrid complications arising sometimes in the course of pulmonary tuberculosis. He administers the remedy usually after the following formula:

R Creasoti f ʒ ss
Tincture gentianæ f ʒ i
Spirit. vini (95°) f ʒ iij
Vini Xerici f ʒ vj

M.—D. S. From three to five tablespoonfuls a day, with milk.

He gives in detail a case of pulmonary gangrene (sequel to an attack of croupous

pneumonia), cured by the remedy in 55 days. The patient's sputa lost its offensive odor on the eighth day of treatment and became simply purulent on the thirteenth day, his general state and the condition of the lungs steadily improving almost from the very beginning of the treatment. On the twenty-eighth day the mixture was discontinued. In six days, however, a relapse followed. The treatment having been resumed, all symptoms again improved in a few days.

Bloodless Treatment of Fistulæ.

In the Moscow therapeutic weekly *Novosti Terapii*, No. 11, 1889, Dr. Gëorgiy I. Tarabrin, of Ekaterinovka, warmly recommends the treatment of incomplete fistulæ (sinuses) by the intrafistulous injection of a two per cent. solution of carbolic acid or a solution of corrosive sublimate (from three to ten grains to six ounces of distilled water), repeated two or three times a day. The injection should be preceded by probing (in order to determine the direction which the jet should take). It is advisable to commence the treatment with a weak solution and then to gradually pass to stronger ones. The treatment is said to prove successful in a couple of weeks even in old cases of deep fistulæ penetrating into bone.

Cornutine.

Dr. Thomson, of Dorpat, recently made an extended study of the actions of cornutine, and has found that it is especially effective in atonic hemorrhage after child-birth. Unfortunately it is very unstable (in solution) and high in price. Dr. Thomson recommends the following formulæ:

1. Cornutine ¾ grain.
Distilled Water 150 min.
Hydrochloric Acid 4 drops.

Dissolve. Keep in a dark (amber-colored) vial. Dose: 15 minims hypodermically.

2. Cornutine 4 grains.
White Bole 140 "
Glycerin and Water q. s.

Make 60 pills. Dose: 2 to 3 pills daily.—*American Druggist*, Dec., 1889.

Jan. 4, 1890.

Editorial.

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CHARLES W. DULLES, M.D.,
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When it is desired to call our attention to something in a newspaper, mark the passage boldly with a colored pencil, and write on the wrapper "Marked copy." Unless this is done, newspapers are not looked at.

The Editor will be glad to get medical news, but it is important that brevity and actual interest shall characterize communications intended for publication.

IN MEMORY OF

JAMES H. HUTCHINSON, M. D.

It has been but a few days since Dr. James H. Hutchinson courteously gave to a representative of the MEDICAL AND SURGICAL REPORTER his views on the subject of Cremation, as published in the number for December 28, which was issued on the very day of his sudden death—December 27. So little did any of his professional brethren anticipate the closing of his honorable and honored career as a man and as a practitioner of medicine. We publish in another part of this issue a brief sketch of his life, but here we pay our own tribute to the worth of a character which we believe may well serve as a model for those who strive to attain success by strict integrity, by unflinching devotion to truth, by patient and perse-

vering labor in the field of work to which Providence has called them. Those who knew Dr. Hutchinson best know best how thoroughly he was attached to the principles which make fine character in any calling, and which contribute most to keeping the medical profession from the deterioration to which the sharp competition of the present day is continually pressing it. He was a man who would not seek his own advancement at the expense of any of his brethren, nor permit the legitimate endeavor to secure the good opinion of his fellow-men to degenerate into a selfish struggle to push ahead of his fellow-practitioners. His character was marked by a most attractive modesty, by due respect for his equals and consideration for his juniors, and by a kindly charity for those with whom he differed on important questions. He was a warm friend, an upright and sagacious counselor, and a thoroughly honorable man.

Such men are doubly useful—useful in what they do, and useful in what they prompt others to do; and it is a comfort to believe that when they are withdrawn from the former field of usefulness, their influence in the latter continues and expands with the development of every man on whom their example has impressed the stamp of devotion to "whatsoever things are true, whatsoever things are honest, whatsoever things are just, whatsoever things are of good report."

TREATMENT OF MEASLES.

What is demanded in the treatment of measles is not a certain number of medicines, appropriate for meeting the indications of the average case, but a just conception of the course of the disease, of the symptoms which indicate danger, and of the complications and sequelæ to which the patient is liable. The physician should also know the best methods of preventing and of overcoming the sequelæ.

A mild case of measles, in a reasonably

healthy child, will probably end in recovery without any medicine, if the child is kept in a warm room free from draughts, and has its chest well protected. This fact, however, does not justify the physician in declining to administer medicine; for the little patient can be made much more comfortable by remedies directed to relieve the irritating conditions induced by the fever. If the cough is troublesome, it may be allayed by a suitable sedative; if there is headache with much restlessness, acetanilide in small doses will prove an acceptable calmate. If the skin is hot and dry, citrate of potash with lemon juice and syrup may be given as a febrifuge. Such remedies serve the double purpose of relieving the patient and of convincing the family that the sufferer is not neglected.

The sooner a physician is consulted in a case of measles the better. He should explain to the parents at the outset that the greatest danger which threatens the patient is the occurrence of respiratory troubles, which are most likely to develop shortly after, or just as, the eruption disappears. They are therefore early sequels. They should be guarded against by extreme care from the very beginning of the disease. The child should be put to bed in a part of the room in which he will be least exposed to draughts. A warm close room is better than a large airy one, with abundant ventilation; for the duration of measles is not protracted, and there is more to be feared from currents of air than from impure air. The patient should not be placed near a door or a window, if this can possibly be avoided. When it cannot, some protection against draughts will be afforded by screens suitably adjusted about the bed. The chest of the child should be protected by a good warm undershirt, or, what is better, a cotton jacket made by quilting raw cotton inside an undershirt.

The respiratory troubles most likely to occur are acute non-membranous laryngitis, bronchitis, and catarrhal pneumonia. A

varying amount of bronchitis is normally present throughout an attack of measles, but the cough should abate with the subsidence of the fever and the disappearance of the eruption. If at the latter period the respiration should become accelerated, the temperature rise, and especially if there should be some blueness around the finger or toe nails, the greatest apprehension may be warranted. These symptoms indicate that pneumonia is developing. The occurrence of blueness is evidence that oxygenation of the blood is defective, and is of the gravest omen. The aspect of the patient when the blueness has spread to the face and other parts of the body has given the name "black measles" to this severe form of the disease. As every one knows, black measles is extremely fatal. Sometimes the cyanosis which characterizes it develops so soon after the appearance of the eruption that it is difficult to decide, especially if the eruption has not been very distinct, whether the pneumonia is a complication or a sequel; but it is probably the latter.

The treatment of the pneumonia following measles is the same in principle as that of any other catarrhal pneumonia; but the affection is more fatal, requires more skill and judgment in its management, and freer stimulation than an ordinary pneumonia. A larger supply of fresh air is now required by the patient. If he is surrounded by skilled and faithful attendants, the cotton jacket may be discarded for poultices of ground flaxseed and mustard, the proportion of the latter being regulated by the age of the patient. These poultices should be large enough to cover both sides of the chest, back and front. They should be hot, not too thick, and be covered on the inner surface with a thin layer of olive oil or lard oil, so that they can be used very hot without danger of blistering. The poultices will require changing about every three hours; when properly used they are better than the cotton jacket in the early stages of the pneumonia. To get the desired results from

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them, however, skill, deftness, and fidelity to directions are required. When not made and applied properly, they are useless for good, and may become an element of danger by inspiring a confidence in their efficacy which is groundless, and by exposing the patient to chill when they are changed.

For these reasons, in all ordinary cases, the cotton jacket is preferable. Its protective power, however, requires to be increased by a covering of oil silk, and counter irritation to the chest should be obtained by daily applications of tincture of iodine. When a considerable area of one lung is consolidated, resolution can be promoted by the use of a fly blister. Such a procedure is contrary to the advice of many writers, but it is productive of the greatest benefit in certain desperate cases in which it is of vital importance to secure resolution promptly. Unfortunately, in some of these cases, the consolidated area in one lung clears up, but another develops in the opposite lung. When both lungs are affected seriously, and there is general bronchitis of the medium-sized and smaller tubes, turpentine stupes are better than either iodine or a blister. Feeding should be with liquid foods, given in small quantities frequently.

The medicines which are most serviceable in pneumonia, following measles, are the preparations of ammonia, especially the carbonate, whiskey and brandy, digitalis, strychnine, and oil of turpentine. Each should be given singly, or combined, in doses sufficient to produce the desired effect. Regarding digitalis, it may be worth noting that it acts best when given in small doses at frequent intervals. Strychnine is indicated especially in the later stages of grave cases, in which the heart and the respiratory muscles show signs of failure; and turpentine when a typhoid condition exists.

High temperature will demand attention in a small proportion of cases of pneumonia. Antipyretic medicines should be avoided, and reliance placed on sponging, except over the chest, with cold or iced water.

Sleep is very important, but it requires great nicety of judgment to decide whether sedatives are likely to do more harm than good, by favoring the outpouring of secretion into the bronchial tubes.

Under the treatment thus outlined, many patients will be conducted safely through the most frequent and the greatest danger which threatens a person suffering from measles. It is not forgotten that other inflammations—for the most part of mucous membranes—occur; they cannot, however, be considered in the present Editorial. We have tried merely to outline a prudent treatment for an ordinary mild case of measles, and for one of the severest that can tax the skill and ingenuity of the physician.

CONSISTENT HOMŒOPATHY.

A struggle for consistency in the ranks of the so-called school of homœopathy, which must enlist the sympathy of all who regard consistency as a virtue, is going on at the same time in Philadelphia and New York. In this city several physicians connected with the homœopathic hospital have resigned within the past few months, because—as they assert—they cannot yield even a tacit approval to practices there which are not in accordance with the homœopathic standards. In New York a contest is going on between the New York County Homœopathic Society and the Medical Board of the Ward's Island Hospital. By an overwhelming vote the Society has petitioned for the reorganization of the Board—sixty-three to six. The petition asks the reorganization of the Medical Board of the hospital, and the Homœopathic Society is very earnest in its determination to oust all members of the Board who hold doctrines which homœopaths deem heterodox.

Whatever effect this movement, and the sentiment in other places, may have upon the standing of homœopathy as a general method of practice, there can be no ques-

tion that it is in the interest of truth and honesty, and so deserves the approval of right-minded men.

MUTUAL AID SOCIETY FOR NURSES.

At a meeting of the Directory of Nurses, held in the College of Physicians of Philadelphia, Dec. 17, officers were elected for a society intended to protect and give sick benefits to all trained and registered nurses who are members of the organization. At the meeting held last week there were one hundred and twenty names enrolled, and since that time twenty-five new names have been added to the list. There are between six and seven hundred trained nurses now registered at the College of Physicians, and it is hoped to soon have the greater number of these as active members of this new organization, so that the sick benefits may be increased accordingly.

The purpose of this organization is entirely commendable, and if it meets with the success it deserves, it cannot fail to advance the standing and best interests of nurses as a class, and to prove indirectly of great benefit to the community.

PHILADELPHIA HOSPITAL AFFAIRS.

The hope expressed in the last number of the REPORTER that we should not soon have to express disapproval where praise would be a more agreeable exercise has been disappointed. The Board of Charities and Correction of Philadelphia met December 30, and by a solid vote of those of its members who are supposed to be the creatures of the Mayor displaced nine members of the Medical Staff of the Hospital against whom no charge of unfitness could be brought, and put nine new men in their places. This action has brought upon the unworthy members of the Board the condemnation of every newspaper in Philadelphia which is deserving of respect, and we may leave them to the judgment of their fellow-citizens.

But, as a representative of medical opinion, the REPORTER expresses its regret and disappointment that so many medical men of Philadelphia should not be ashamed to take places made vacant by the summary dismissal of professional brethren who have given years of faithful and efficient service to the Philadelphia Hospital, or to get what advantage they can from a disgraceful political manœuvre. Some of the names in the list of shame we are surprised to find in such company; but some are those of men who have not yet made such an impression on the medical profession as justifies any surprise at their present position.

"O tempora! O mores!"

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the REPORTER.]

TRANSACTIONS OF THE MEDICAL SOCIETY OF NEW JERSEY, one hundred and twenty-third annual meeting, held at Asbury Park, June, 1889. 8vo, pp. 242. Newark, 1889.

The New Jersey Medical Society enjoys the distinction of being the oldest State Medical Society in this country. The present volume shows that its members have not fallen into mental decay with age. The President, Dr. H. Genet Taylor, of Camden, N. J., says in his address: "A weeding out of incompetent physicians can be best attained in our own State by the appointing in every County Society, and in our State Society, of a permanent committee to watch for every illegal practitioner locating in their jurisdiction; to examine the diplomas registered in the clerk's office, and if any were issued by doubtful colleges, to make inquiry about their standing, and to make a report to this Society at least once a year." In Pennsylvania we have thought the best protection against both illegal and unqualified practitioners could be obtained most certainly by a State Board of Medical Examiners; but undoubtedly there is room for a difference of opinion. Dr. W. Updyke Selover, of Rahway, in an essay on the subject, expresses the opinion that intubation of the larynx has certain advantages over tracheotomy. Dr. H. M. Weeks, of Trenton, has an essay on "Some Recent Advancements in Pelvic Surgery." Dr. J. G. Ryerson one on "Perityphlitis." Dr. J. D. Osborne, of Newark, an essay on the antiplastic action of calomel, in which he urges the revival of its use for this purpose; while Dr. William Perry Watson, of Jersey City, contributes an interesting essay on "The Value of Creasote in Fifty Cases of Disease of the Air Passages." The rest of the volume is taken up with the Report of the Standing Committee, Obituaries, and Reports of the District Societies.

The value of the Transactions would be increased if there were more essays, and if the discussions upon them were published. In this connection it is a

pleasure to note that at the next annual meeting, which will be held at Schooley's Mountain, on the second Tuesday in June, the following interesting and important subjects will be brought up for discussion: "Does the Early Administration of the Salicylates in Acute Articular Rheumatism Prevent Heart Complications?" "Hydrophobia;" and "Is Diphtheria Primarily a Local or a Constitutional Disease?"

A CLINICAL ATLAS OF VENEREAL AND SKIN DISEASES. BY ROBERT W. TAYLOR, A. M., M. D., Surgeon to Charity Hospital, New York; Late President of the American Dermatological Association, etc. Illustrated with 192 Figures and 48 colored Plates, etc. Parts VII, VIII. Philadelphia: Lea Brothers & Co., 1889. \$2.50 per part.

Dr. Taylor's great work, as now completed, contains one hundred and ninety-two figures, many of them life-size, and representing the highest perfection of the chromo-lithographic art, while scattered throughout the text are a large number of engravings. Some of these illustrations are from the author's own collection, while for others the best atlases of the world have been drawn upon for typical pictures of different types of skin and venereal disease. As a whole the work is eminently successful. It is exceedingly handsome, and remarkably faithful to nature, while Dr. Taylor's reputation as a dermatologist, as well as syphilographer, insures a high value to the text of his book.

He is to be congratulated on the successful termination of this important undertaking; and the publishers on the magnificent shape in which they have brought it out.

TRANSACTIONS OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND. Ninety-first Annual Session, held at Baltimore, Md., April, 1889. 8vo, pp. 264. Baltimore, 1889.

This volume contains the papers read before the Faculty, April 24-27, 1889. An abstract of the proceedings was published in the *REPORTER*, May 18, 1889, so that an extended review of them now is unnecessary. Those, however, who were attracted by the references to the papers should obtain the present volume, which is unusually full of good matter and is well printed and firmly bound. The Transactions as a whole reflect great credit upon the Faculty and upon the Publication Committee.

A MANUAL OF OBSTETRICS. BY A. F. A. KING, A. M., M. D., Prof. of Obstetrics and Diseases of Women and Children, Medical Dept., Columbian University, etc. With one hundred and forty-one Illustrations. Fourth Edition. 12mo, pp. 431. Philadelphia: Lea Bros. & Co., 1889. Price, \$2.50.

The fact that King's Manual of Obstetrics has passed through four editions in little more than seven years is ample evidence that it meets with popular favor. The reasons for this are not far to seek. The reader is fairly surprised at the amount of matter the book contains. Almost every subject in obstetrics is at least touched upon; the more important topics being fully treated. In general, the author's exposition of the subject is excellent, giving, as he does, generally accepted views. These features render the manual of especial value to the medical student, to read during attendance on lectures, and to use when preparing for examination. The practitioner also will find here modern views presented in concise form.

We observe with regret, however, that in some important chapters the present edition has not been sufficiently revised. In our knowledge of the Cæsarean section, and extra-uterine pregnancy, especially, great progress has been made in the last few years; but Dr. King has failed to set forth the recognized standards of the present time. This, we believe, is unfortunate in a book from which students will derive their "first impressions" concerning these subjects; because first impressions have the force of prejudices in later life. This is a defect which we hope to see corrected in the next edition.

LITERARY NOTES.

—*The Ophthalmic Review* begins its new volume with an American editor, Dr. Edward Jackson, of Philadelphia, who succeeds Dr. James Anderson, of London. It will hereafter contain original articles from American as well as English ophthalmic surgeons; with notices of all ophthalmological papers published here or abroad, and full reviews of the more important of them. Those who are familiar with the thoroughness, conscientiousness and literary talent of the new editor will congratulate the *Review* on its acquisition.

NEW REMEDIES AND APPLIANCES.

In this department, notice will be given of Remedies, Food Articles, and Instruments or Surgical Appliances of which specimen are sent to the Editor; it will bear the same relation to these articles that the department of Book Reviews now does to books.

A New Inhaler.

Since Blumroder & Henle recommended so strongly the use of etheric inhalations in many diseases of the respiratory organs, numbers of inhalers have been devised. They all were considered imperfect, neither facilitating a deep inspiration, nor a sufficient collapse of the lungs during expiration, and they didn't prevent contact of the expelled expired gas with the medicine in the inhaler.

R. B. Segnitz, of New York, has attempted to overcome this difficulty by designing an instrument, consisting of a tube provided with a bell-shaped mouth-piece, with medicine chamber at lower end which is easily removable and contains a small piece of sponge. The tube contains a small ball valve, made of cork, intended to open on inspiration and to close on expiration. The expired gas is intended to escape by opening a flute valve in the middle of the tube.

The design of Dr. Segnitz's instrument is ingenious, but it has two defects which it would not be very hard to remedy: one is, that the ball valve does not act perfectly, and the other that the flute valve opening is much too small.

Glycerine Suppositories.

Eli Lilly & Co. have sent us specimens of glycerine suppositories which are superior to any preparations of the kind which have come to our notice. They are elliptical in shape and covered with a thin waxy coating, which is very easy to remove and which forms the best protection against combination of the glycerine with moisture in the air and the resulting stickiness.

NOTES AND COMMENTS.

The Phonograph in Otology.

Dr. Lichtwitz, in the *Wiener Med. Presse*, Nov. 17, 1889, proposes an interesting use for the phonograph in aural examination. We have in ophthalmology fixed scales by which the range of vision may be accurately measured; there exist, however, no similar methods by which the intensity of hearing may be determined upon. With the aid of the phonograph Dr. Lichtwitz proposes to establish a fixed scale of phonograms, of varying intensity, and graded similarly to the optometric scale. These phonograms may be tried in succession, by the aid of the hearing tube of the phonograph, similarly as one would adapt glasses when testing the vision; and thus the patient's range of hearing can be accurately determined.

By this method it will be possible for otologists to reach a universal understanding regarding this most important point in aural examination.

Cancer of the Bladder.

At the meeting of the Pathological Society of London, held Dec. 3, Mr. Hurry Fenwick brought forward specimens of cancer of the bladder, to illustrate some unusual phases of that disease. The first one demonstrated the frightful rapidity which was sometimes exhibited by vesical carcinoma. The growth, which occupied the entire middle zone of the bladder, had been proved by means of the electric cystoscope to have grown in four weeks. The patient had been previously operated upon by the suprapubic method, and a single pedunculated carcinomatous growth had been completely removed.—*Lancet*, Dec. 7, 1889.

A Leper in Court.

Something of a panic was created recently in a St. Louis court, when a leper was produced on a writ of habeas corpus. The writ was directed against the city officials, who were directed to bring the leper from quarantine in order to demonstrate to the court that the man was really a leper, and was not being unlawfully restrained of his liberty. The Judge took one glance at the man, and was immediately convinced that he was a genuine leper, and ordered him back to quarantine, after which the court was adjourned to give the janitor a chance to fumigate and air the place.

A Modern Milk-Woman.

A woman in New Hampshire has undertaken a milk farm, not merely to give the usual canned or glass supply for exacting customers, but to furnish also sterilized milk. This farm is in the pine region of New Hampshire, and the herd has a physician. The milk is sterilized and hermetically sealed in six-ounce bottles, which is a sufficient quantity for a child to take at one feeding. The heat of the water-bath, which is used to destroy any possible disease or fermentation germs in the milk, is applied as immediately as possible after the milk is drawn from the cow.

Notification of Infectious Diseases.

The *Lancet*, commenting on the passage of the English infectious disease notification bill, says, "One thing is remarkable in this legislation,—the slight resistance which politicians of advanced views have been able to offer to its fundamental principle; viz., the right of the community to insist on knowing the affairs of individuals and families where these are likely to involve in any degree the health of others: in other words, the subordination of the individual to the community. This is, of course, the fundamental principle of society, but it is ever undergoing fresh development. National education, vaccination, isolation, and notification of disease, are all illustrations of the same principle. We have ourselves no hesitation in accepting the principle that individual liberty must give way where such doubtful advantages as the freedom to have small-pox and scarlet-fever are the only badges of

liberty; and it will involve no misfortune to the world if many other rights claimed by well-meaning but discordant individuals are curtailed in the interests of society."

Storing Food in Inhabited Rooms.

A writer in the *Gazette Médicale de l'Algérie* calls the attention of hygienists to the danger of eating butter impregnated with dangerous miasmata. Frequently the butter is kept in inhabited rooms, and sometimes even in rooms occupied by sick persons. Milk also is often kept in the same manner. The result is a contamination by morbid germs. Care should therefore be taken to obviate these grave risks to the public health.—*Lancet*, Dec. 7, 1889.

Ward's Island Hospital.

The Homœopathic Society of the County of New York is fermenting and excited. The cause of this ferment is the Medical Board of the Ward's Island Hospital. The Society has petitioned the proper authorities to dissolve the present Board, in which, it is asserted, there are four or five members who do not profess fealty to the Homœopathic School, and appoint a new one from a designated list of members of the Society. The Commissioners of Charities and Correction, to whom this petition was addressed, have sent to the secretary of the Society for a list of all its members, and for the names of those who voted for and against the resolution petitioning for the dissolution of the Hospital Board and the deposition of its president and secretary. When this information is received it will be placed before Dr. Guernsey, President of the Board, for answer.

Salicylic Acid in Soft Chancres and Syphilitic Condylomata.

In the St. Petersburg weekly *Voënnno-Sani tarnoiž Dëlo*, No. 21, 1889, p. 263, Dr. Leopold K. Golistewski, of Poti, draws attention to the abortive treatment of soft chancres according to Hebra's method, consisting in powdering the chancres with pure salicylic acid daily. Two or three applications (after previously cleansing and drying

the ulcer) are said to be sufficient for transforming the chancre into a simple ulcer, which heals kindly in two or three days. In a case adduced by the author, which had remained without any treatment for fifteen days, a complete cicatrization ensued about nine days after the first powdering. The method seems to be equally successful in syphilitic condylomata, as is illustrated by a case of Dr. Golistewski in which multiple perineal warts (resisting the influence of calomel, mercurial inunctions, etc.) disappeared tracelessly in a week, after five applications of the acid. The same may be said in regard to suppurating buboes.

Antiseptic Treatment of Puerperal Eclampsia.

Dr. Maurice Rivière, of Bordeaux, speaks highly of the results obtainable by the antiseptic treatment of puerperal eclampsia. He outlines his method of treatment in the *Gazette hebdomadaire*, Nov. 22, 1889, as follows:

I. Preventive Treatment.—First, a strict milk diet should be enforced and one of the following capsules given every two hours:

R Naphthol gr. xxxviii
Sacchar,
Bismuthi salicyl. aa gr. xxxj
M. et div. in caps. No. viij.

Second, every third or fourth day saline aperient or a dessertspoonful of sulphate of soda in a wineglassful of water should be given. Third, the functions of the skin and kidneys should be stimulated by hot baths given twice a week.

II. Curative Treatment.—First, absolute quiet and repose of the patient should be insisted upon. Second, ten to fourteen fluid ounces of blood should be taken from the patient in order to reduce the quantity of poison in the system. Third, the following potion should be administered:

R Aquæ dest.,
Syrup. pruni Virginianæ aa f ʒij
Chloral. hydrasis,
Sodii bromid aa ʒss - ʒj

Fourth, clysters containing half to one drachm of chloral may be administered and chloroform anæsthesia resorted to if necessary. Fifth, Dr. Rivière urges that any

forcible attempt to expedite the birth of the fetus, during labor, should be avoided, since such procedures only irritate the cervix and are likely to do harm. After the birth of the fetus blood-letting is useless, and any possible good that would have been obtainable by it, has been accomplished by the physiological hemorrhage.

Hypnotic Suggestion in Hysterical Paralysis; Hypnoscope.

In the St. Petersburg semi-weekly *Meditsina*, Dr. M. V. Pogorelsky, of Elisavetgrad, details a striking case of a hospital nurse, 23 years old, with hysterical paralysis of all the limbs, body and bladder, which was cured by ten sittings of hypnotic suggestion (during the course of 24 days), after all ordinary means (electricity, oxygen inhalations, strychnia, steel, etc.), had utterly failed to bring any relief. A great improvement, viz., return of movement in the upper limbs, and, to a slighter degree, in the legs, was obtained even after the very first *stance*, which fact, by the way, enabled the author to at once settle the differential diagnosis, since some of his colleagues had regarded the case as one of post-diphtheritic paralysis. The same author recommends a simple hypnosopic test. As is known, out of every 100 persons only 40 can be brought into a hypnotic state (that is, they are "mediums"), while the remaining 60 cannot be hypnotized by any procedure in vogue (Obersteiner). In view of this fact, many attempts have been made, in striving to discover some means by which one may make an easy and rapid differentiation between a medium and a non-medium. Diagnostic appliances of the kind, or "hypnoscopes," were proposed, for instance, by Gessmann, Marcy, Ochorowict, etc. Starting from Ochorowict's principle, Dr. Pogorelsky suggests the following test, which gave satisfactory results in several scores of cases experimented upon by himself. He takes an ordinary middle-sized horse-shoe magnet, and, while holding it vertically, orders the patient to place his or her forefinger in the outlet in such a manner that the ball should look downwards and the lateral aspects of the phalanx come to rest lightly on the respective inner surfaces of the branches. The patient's forearm and hand should be placed on a table and remain motionless. Be the person experimented upon a medium,

he or she, very soon (in from one to seven minutes) commences to experience peculiar sensations about the finger—such as pricking, twitching, pressure, numbness, cutting pain, etc.,—which not unfrequently spread to the palm, other fingers, and even sometimes up the forearm, arm, and down the whole corresponding side of the body (including the thigh), and ultimately may involve the opposite hand, etc. No phenomena of this kind are induced by the magnet in the case of non-mediums.

Hyderabad Chloroform Commission.

The following telegram from Dr. Lauder Brunton appears in the *Lancet*, Dec. 7, 1889: "Four hundred and ninety dogs, horses, monkeys, goats, cats, and rabbits used. One hundred and twenty with manometer. All records photographed. Numerous observations on every individual animal. Results most instructive. Danger from chloroform is asphyxia or overdose; none whatever heart direct." These results apparently indicate such a complete reversal of the view held by Dr. Lauder Brunton at the time he left England—that one of the dangers resulting from chloroform is death by stoppage of the heart—that the details of the experiments made by Dr. Brunton, and the reasons for the conclusion he has evidently arrived at, will be awaited with the greatest interest by the profession.

A Maniac's Brain.

The brain of the maniac-homicide, Daley, who killed J. G. C. Kennedy some years ago, and who committed suicide at St. Elizabeth's a few days since, has been examined. It was found to weigh fifty-nine and a quarter ounces. It was to all appearances in good order, and exhibited, macroscopically, no symptoms of disease or malformation.

Pseudo-Hydrophobia.

It is reported from New York, under date of Dec. 19, that a boy, 15 years old, died that morning at Bellevue Hospital, a victim to the fear of hydrophobia. He was bitten on the hand about two weeks before, and soon became overcome by the fear that he would have hydrophobia. The day before he died, while preparing to go to work, he suddenly began to stare wildly about him, to

shout and gesticulate, and soon he tried to throw himself from a window. His family caught hold of him, and a desperate struggle ensued. Two policemen were summoned, and it required the exercise of all their strength to bind and handcuff him. In this condition he was removed to Bellevue Hospital. Throughout the day the lad continued violent and made repeated attempts to bruise and injure himself by throwing himself on the floor.

Dr. Douglass, of the hospital, said that there had not been the slightest symptom of hydrophobia about the boy, but that the fear of that dreadful disease had without doubt unsettled his reason. His fear of hydrophobia had been greatly intensified by reading an account of the death of another boy.

Statistics of Leprosy in the United States.

In view of the general impression that Leprosy is spreading in this country, it is desirable, in the interest of the Public Health, to obtain accurate information upon this point. Dr. Prince A. Morrow, editor of the *Journal of Cutaneous and Genito-Urinary Diseases*, 66 West 40th Street, New York, is engaged in collecting statistics of all cases of Leprosy in the United States, and he asks members of the profession to aid in this work by sending to him a report of any case or cases under their observation, or coming within their knowledge.

Information is requested as to location, age, sex, and nationality of the patient, and the form of the disease—tubercular or anæsthetic; also any facts bearing upon the question of contagion and heredity.

NEWS.

—Dr. R. L. Moore has removed from Spring Valley, Minn., to Lincoln, Neb.

—The virulence of the outbreak of typhoid fever which recently raged in Dublin, was, by Dec. 1, abating. The type of the disease was mild, and the mortality has not been large.

—A graduate of the Jefferson Medical College was recently refused a license to practice in Minnesota because his studies had not covered "three courses of at least six months each," as required by the laws of that State.

—Dr. Bramann, first assistant in Professor von Bergmann's clinic at Berlin, who performed tracheotomy on the late Emperor Frederick the Third, has declined to accept a "call" to Greifswald as Extraordinary Professor of Surgery.

—According to a lay exchange, Dr. R. S. Huidekoper, until recently connected with the Veterinary Department of the University of Pennsylvania, has been offered a position in the Harvard College Veterinary Annex, but has not yet abandoned his thought of starting a school of his own.

—Leo Lesquereux, the Nestor of botanists in the United States and a well-known student of paleontology, died recently at his home in Columbus, O., at the age of eighty-two. Lesquereux was born at Fleurier, near Neuschâtel, in 1806. He was educated in Neuschâtel, and later occupied chairs at several European educational institutions. At twenty-five he became totally deaf. In 1848 he came to this country, influenced to this step by Agassiz.

—Some alarm has been created by the discovery that a Long Island establishment has been making sausages out of horse-meat. There is, however, nothing poisonous or unwholesome in horse-meat. The only objection that can be made to this kind of food is that sound and healthy horses are too expensive to be eaten, hence it is to be assumed that the horse-meat of butchers' shops does not represent the noblest type of a noble animal.

—The Calcutta Public Health Society has reported strongly in favor of leper legislation, and urges that the provisions of the bill already drafted should be strengthened and extended so as to prohibit the employment of lepers in washing clothes, preparing food and similar occupations. Native opinion is, however, generally averse to legislation going beyond pauper lepers, on the ground that the contagious character of the disease is not sufficiently established.

—Statistics, recently published on the authority of the Sanitary Department of the Russian Ministry of the Interior, show that in 1887 the population of Russia was 110,482,627. During that year the births amounted to 4,884,447, and there were 3,288,838 deaths. The total number of persons who received medical assistance was 16,860,000, the number of medical practi-

tioners throughout the Empire being 17,459. In 1888 the number of doctors had risen to 18,334, and this did not include 698 women holding the diploma of Doctor of Medicine.

—The Boston *Record* estimates that over 2,000,000 quinine pills, weighing about a ton, have been consumed by the people of that city during the past ten days. It arrives at this conclusion after interviews with druggists and physicians, one wholesale drug firm alone reporting a sale of 50,000 pills on last Saturday. This is a larger quantity than Boston usually consumes in a whole year, and it gives about five pills to every man, woman and child in the city. It shows how strong a hold "la grippe" has taken on the locality. If other cities consume a proportional quantity of this drug during the prevalence of the influenza epidemic, a serious inroad on the supply of quinine will be made, and an advance in its price may be the result.

OBITUARY.

DR JAMES H. HUTCHINSON.

Dr. James H. Hutchinson died suddenly at his residence in Philadelphia, Dec. 27, 1889, of uremia. On Wednesday night he retired in good health, and on Thursday morning arose to take his bath. Some considerable time later he was found unconscious. Drs. Ashhurst and Sinkler were summoned, but medical skill failed to revive him, and he died without having uttered a word from the time he was stricken.

Dr. Hutchinson belonged to one of the oldest families in Philadelphia. He was born at Lisbon, Portugal, in 1834, when his father was U. S. Consul there. In early life he was sent to a boarding-school in New Haven, Conn. Later he returned to Philadelphia and entered the University of Pennsylvania, from which he was graduated in arts, and in medicine in 1858. He then served a term as resident physician of the Pennsylvania Hospital, after which he spent a year in Europe, visiting the hospitals in Paris and Vienna.

Upon his return to Philadelphia he took up the practice of his profession and became prominent in a number of professional, philanthropic and educational institutions. He was Vice-President and Honorary Librarian of the College of Physicians; was

an influential Manager and Chairman of the Household Committee of the Pennsylvania Institution for the Instruction of the Blind; was a Trustee of the University of Pennsylvania, and took a deep interest in its progress. He was a Director of the Philadelphia Library, and was an attending physician at the Pennsylvania Hospital and the Children's Hospital. He was also a vestryman of St. James' Protestant Episcopal Church. He leaves a widow and five children.

A special meeting of the College of Physicians was held on Saturday afternoon, Dec. 28, to take action on the death of Dr. Hutchinson, and the following minute was unanimously adopted:

"The College of Physicians of Philadelphia has heard with profound regret of the death, after only a few hours' illness, of its Vice-President, Dr. James H. Hutchinson, and hereby records its profound sense of the loss—to human eyes irreparable—thus occasioned, not alone to its own body, but as well to the whole medical profession of the city and vicinity, and to the entire community.

"Still in the prime of life, with skill and knowledge broadened and confirmed by wide and ever-growing experience, Dr. Hutchinson shone prominent both as a faithful and trusted family physician, and as a consultant whose advice and assistance were largely sought for and highly prized by his fellow-practitioners, all of whom recognized both the value of his counsel and the uniform candor and conscientious honesty with which it was bestowed.

"A Fellow of this College for more than a quarter of a century, he served it in council and committee-room, with a zeal and fidelity which are amply witnessed by its transactions and by the records of its library, and which but met its just recognition in his unanimous election to the honorable office of Vice-President.

"A scholarly and accomplished writer; an able clinical teacher; a skilful and judicious practitioner, well exemplifying the highest and best type of the practical physician; a high-minded, honorable Christian gentleman, tried and true in all the various relations of an active, busy life—his death leaves a gap which can never be filled; a precious memory which will endure long after those who now grieve for him shall themselves have passed away forever."

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